ROUTLEDGE

Trancework

An Introduction to the Practice of Clinical Hypnosis

FOURTH EDITION

Michael D. Yapko

Trancework

FOURTH EDITION

PRAISE FOR *TRANCEWORK*

"This is an almost encyclopedic compendium of information for anyone serious about studying hypnosis. Michael Yapko's presentations are always well received. It is inclusive and well indexed as both a study guide and reference book. I recommend it highly."

–Dabney M. Ewin, MD, Clinical Professor of Surgery and Psychiatry, Tulane Medical School, Louisiana

"The art of therapy is the fusion of scientific understanding and clinical insight. Michael Yapko's fourth edition of *Trancework* is an artistic achievement. He presents the latest neuroscientific research in easy to understand fluid prose and he takes on the controversies in our field with wisdom and grace. He describes interpersonal communication with uncanny sensitivity and humor, and uses his insights to enhance the foundation of all our work—the doctor–patient relationship. In the end, he teaches us that the adjunctive use of clinical hypnosis opens our doors to wonderful possibilities of enhanced patient care. Dr. Yapko has done it again!"

–Peter B. Bloom, MD, Past President, International Society of Hypnosis, Clinical Professor of Psychiatry, University of Pennsylvania Perelman School of Medicine, Pennsylvania

"*Trancework 4th Edition* exceeds the highest of expectations established from the previous editions. Michael Yapko has successfully accomplished the difficult task of blending extensive and current research with highly understandable, interesting, and clinically insightful text. This comprehensive book covers a wide range of topics that well represent the many facets of the field of hypnosis, and inspires readers to see the relevance of hypnotic principles and methods in virtually every clinical interaction. Yapko's depth of experience is evident on every page and gives everyone from the basic learner to the seasoned practitioner words for what they need to know as well as what they didn't know they knew. *Trancework* gets my highest recommendation."

–Betty Alice Erickson, MS, private practice, Dallas, Texas

"For almost 30 years, Michael Yapko has been a leader in the field of clinical hypnosis, and *Trancework* has been the 'go-to' handbook for the novice and expert practitioner alike. A master clinician, with loads of practical experience and sage advice to share, Yapko is also attentive to scientific evidence—not just the results of studies of clinical effectiveness, but also the basic science, psychological and physiological, on which clinical practice must be based if it is going to succeed. This fourth edition is thoroughly updated, and belongs on the shelf of everyone who is interested in clinical hypnosis."

–John Kihlstrom, PhD, Professor, Department of Psychology, University of California, Berkeley

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FOURTH EDITION

Michael D. Yapko

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DEDICATION

Through each of the incarnations of *Trancework*, I have dedicated my work "with love to my wife, Diane, who has kept me deeply absorbed in the happiest of hypnotic states." And 35 wonderful years later, these words were never truer.

CONTENTS

Acknowledgments xi
List of Tables xiii
Frames of Reference xv
Foreword xvii
Introduction to the Fourth Edition xxi

PART I
Conceptual Framework

Chapter 1
What Is Hypnosis and Can It Help? 3

Chapter 2
The Myths About Hypnosis and a Dose of Reality 21

Chapter 3
Conceptualizing Hypnosis 47

Chapter 4
The Brain in Hypnosis 63

Chapter 5
Matters of the Mind 89

Chapter 6
Contexts of Hypnosis 105

Chapter 7
Hypnosis in Behavioral Medicine: Amplifying the Mind–Body Relationship 121

Chapter 8
The Social Psychology of Human Suggestibility 141

Chapter 9
Responsiveness to Hypnosis 165

Chapter 10
The Phenomenology of Hypnosis 181

Chapter 11
Environmental and Physical Conditions for Conducting Hypnosis Sessions ... 197

Chapter 12
Hypnosis and Positive Psychology 203

Chapter 13
Hypnotic Hazards, Legal Considerations, and Ethical Guidelines 217

PART II
Practical Framework

Chapter 14
Assessing Hypnotic Responsiveness 237

Chapter 15
Structuring Suggestions 257

Chapter 16
Helpful Hints for Conducting Clinical Hypnosis Sessions 279

Chapter 17
Formal Strategies of Hypnotic Induction 301

Chapter 18
Informal, Conversational Strategies of Hypnotic Induction 319

Chapter 19
Hypnotic Phenomena: Eliciting and Utilizing Hypnotic Resources 343

Chapter 20
Designing and Delivering Hypnotic Interventions in Treatment 389

Chapter 21
Clinical Hypnosis in Psychotherapy 411

Chapter 22
Treatment Dynamics and Sample Hypnosis Session Transcripts for Common Problems 439

Chapter 23
When People Respond in Less Than Ideal Ways 463

Chapter 24
Hypnosis With Children and Adolescents 475

Chapter 25
Clinical Hypnosis in the Management of Pain 495

Chapter 26
Hypnosis Across Modalities: Parallel Processes 515

Postscript 535

Closure 537

Appendix A: Hypnosis Organizations and Journals for Professionals 539

Appendix B: Supplemental Materials 543

Appendix C: Forewords and Introductions to the Previous Three Editions 545

References 559

Author Index 601

Subject Index 611

ACKNOWLEDGMENTS

As with each of the previous editions of *Trancework,* writing this book has been an intensive labor of love. I remain deeply dedicated to the field of clinical hypnosis; indebted to it for all it has taught me and contributed to my life on so many levels. I have developed friendships with colleagues I treasure, shared in the extraordinary achievements of people who have contributed so greatly to our collective search for that elusive phenomenon called human potential, and been challenged to continually expand my ideas about myself and others. It has been a privilege.

There are so many people, friends, clients, and colleagues to acknowledge for their contributions that it would be impossible to name them all. But I am confident that they know who they are and will know that I'm raising my glass of gratitude in a toast to them with these words of appreciation.

My wife Diane is and has always been my greatest source of love and support. I simply could not do what I do without her, nor would I want to. She's amazing in so many ways. As we approach our 36th year of marriage, I'm deeply aware of how incredibly fortunate I am to share my life with her.

My friends and family are loving, supportive, and a great gift I never take for granted. My parents, Gerda and Benjamin Yapko, my mom and dad, Madeline and Gerald Harris, my siblings, Brian Yapko, Jerry Groner, Ken Harris, Jackie Harris, and Mitchell Harris, and my very best friends, Wendy, Richard and Megan Horowitz, all provide a love and support I treasure deeply.

I want to single out some colleagues and friends who were especially helpful with this new edition. Peter B. Bloom, MD, was exceptionally generous with his support and comments, often challenging my views and thereby making this a better book as a result. I am grateful. My thanks also to Mark Jensen, PhD, who provided valuable feedback and helped improve both my thinking and writing. Jeffrey Zeig, Peter Sheehan, Norma and Phil Barretta, and Erv and Rose Lee Polster also deserve my sincere thanks for all they have added to my life, both personally and professionally, that inevitably became a part of this

book. The memories of Jay Haley, William Kroger, and André Weitzenhoffer, all special friends and mentors to me, hold a central place in my heart. Their influence on my views of hypnosis is formidable, just as they were.

Finally, I want to acknowledge my editor at Routledge, George Zimmar, PhD, who made this book project possible. Tara Nieuwesteeg was my project editor and Kristi Bennett was my copy editor for this new edition, and both did a great job of making the manuscript much better. Marta Moldvai is senior editorial assistant, and her cheery help was invaluable more times than I can count. Thanks to you, one and all.

LIST OF TABLES

Table 10.1 The Experience of Hypnosis 195
Table 15.1 Suggestion Structures and Styles: Generic Forms 259
Table 16.1 Some Helpful Hypnotic Communication Patterns 299
Table 17.1 Stages of Hypnotic Interaction 302
Table 18.1 Conversational Induction Principles 323
Table 18.2 Assumptions Regarding Confusion Techniques 337
Table 18.3 Pattern Interruption Strategies 338
Table 18.4 Categories of Confusion Methodologies 340
Table 19.1 Classical Hypnotic Phenomena 345
Table 19.2 Age Regression Strategies 353
Table 19.3 A General Age Progression Strategy 358
Table 19.4 Techniques of Hypnotic Amnesia 362
Table 20.1 A Generic Structure for a Hypnosis Session 401
Table 21.1 Assumptions Inherent in Hypnotic Psychotherapy 412
Table 21.2 Symptom Phenomena as Hypnotic Phenomena 414
Table 21.3 General Structure of a Critical Incident Process 419
Table 22.1 Functions of Metaphors in Psychotherapy 441
Table 22.2 Principles of Metaphorical Communication 441
Table 22.3 Structuring Therapeutic Metaphors 442
Table 23.1 Potential Responses to Resistance 471
Table 25.1 Approaches to Pain Management With Hypnosis 504

FRAMES OF REFERENCE

The frames of reference sections sprinkled throughout the book offer interesting and insightful comments from leading figures in the fields of hypnosis and psychotherapy.

André M. Weitzenhoffer, PhD 33

Helen J. Crawford, PhD 79

Milton H. Erickson, MD 97

William S. Kroger, MD 111

Ernest L. Rossi, PhD 127

Theodore X. Barber, PhD 153

Kay F. Thompson, DDS 170

Peter W. Sheehan, PhD 188

Martin T. Orne, MD 225

Ernest R. Hilgard, PhD 243

Jeffrey K. Zeig, PhD 281

David Spiegel, MD 394

Jay Haley, PhD (Hon) 468

Karen Olness, MD 483

FOREWORD

The author of this fourth edition of *Trancework: An Introduction to the Practice of Clinical Hypnosis* needs no introduction, especially after the established success of his three previous editions. Michael Yapko has an outstanding national and international reputation in his field. Amid many accolades, he was recipient of the *Pierre Janet Award for Clinical Excellence*, a lifetime achievement award from the International Society of Hypnosis, as well as The Milton Erickson Foundation's *Lifetime Achievement Award for Outstanding Contributions to the Field of Psychotherapy.* This fourth edition of this classic work shows why his work is so highly regarded by his professional colleagues.

Trancework has spanned 28 years of expert scholarship. The series began with Yapko guiding us to learn the skills of clinical hypnosis and expanded in subsequent editions to reflect the growth of the field and to draw attention to the growing research-based evidence for the merits of clinical hypnosis. In so doing, *Trancework* established itself as an extraordinarily comprehensive guide to training in clinical hypnosis, giving the reader valuable hints on what to do and what not to in clinical hypnosis, familiarity with the full range of hypnotic phenomena, exposure to major theoretical points of view in the field, the practicalities of induction and use of hypnosis, strategies to adopt, and even potential hazards to anticipate and prevent.

Throughout the text, the insights of the book are reinforced by superbly rich clinical material. The third edition consolidated the benefits of the first and second editions and became the book that was described by one expert as "a state of the art sourcebook that spans the depth and breadth of the hypnotic tradition" (Philips, 2003).

This new edition, by offering many new chapters as well as substantial revisions of previous ones, continues the march. It condenses past chapters to emphasize principal messages and provides up-to-date research material on topics ranging from mechanisms of attention to relevant gene expression and behavioral medicine findings. Chapters new to this edition encompass such

significant (and needed) topics as mind–body therapy and hypnosis, hypnosis and positive psychology, pediatric hypnosis, and related contemporary techniques of focusing.

Previous editions have established the tradition of exposing readers to interviews with leading figures in the field. This edition carries on that tradition and thereby provides a more personal glimpse of the innovators and pioneers of the field who each share highly distinctive perspectives on the nature and meaning of hypnosis. Every experimenter, theorist, and clinician in the field necessarily has a particular set of assumptions, preconceptions, or leanings toward a particular point of view. The inclusion of chapters based on personal reflections and presentations uniquely allows those assumptions to become transparent. Not only does the material in this edition provide stimulating discussion of the nature of hypnosis, but it also highlights fascinating material about the authors of those reflections.

One major, overarching set of assumptions and preconceptions in the field of hypnosis relates to the polar dimensions of realism and phenomenalism, the subject of much of my own research. One might ask: To what extent are theory and practical considerations bound to assumptions of the way things look versus the way things really are? In his revised chapter "The Phenomenology of Hypnosis," Michael Yapko recognizes well the need for a practicing professional to respond to the demands of external reality. The practicing clinician must work for outcomes that establish and clarify effective responses to reality, which have to be perceived as helpful and meaningful by the client if therapeutic outcomes are to be deemed beneficial. For instance, when pain exists, the reality of it cannot be ignored. But it is more than only physical pain. As Yapko forcefully and correctly argues, a client's underlying needs and concerns have to be placed in the broader, external setting of the person's family and social environment.

He makes this point often and very effectively, particularly when he describes and analyzes the various phenomena of hypnosis and defines them both in terms of the experience of the subjects and how they are affected and modified by external constraints. Later, Yapko reiterates his position that hypnotic phenomena are the building blocks of experience. He advances the notion that "in varying combinations (or) degrees of purity, the various hypnotic phenomena comprise ongoing experience, whether good or bad." He makes it clear that the treatment dynamics of hypnotic sessions can never be understood completely without realistic assessment of the likely effects of intervening hypnotically and emphasizes this point in his thoughtful presentation of the session material covered in the seven cases in Chapter 22.

As a self-defined practical, introductory guide to clinical work in hypnosis, this revision by no means lacks theoretical sophistication. The book establishes new and stimulating ideas on theory throughout, and his ideas challenge and extend the reader's thinking in many ways. On the contrasting

dimensions of realism and phenomenalism, however, the book is clinically right in emphasizing both, and I'm certain most readers will agree.

The complexity of the field of hypnosis, its various manifestations, and diverse theoretical underpinnings can be daunting. It is a tribute to the skills of Michael Yapko that he manages to capture and convey this complexity in a highly readable form. No one who picks up this book will fail to be guided through the art and science of clinical hypnosis in a highly revealing and scholarly way. This is a book that illustrates the understandings of an expert, an authority in the field, but one who can also communicate clearly what that complexity means. Yapko does this without lessening in any way its ever present encouragement to the reader to learn more. It is a comprehensive book and is referenced extremely well. One can dip into it at almost any clinical, theoretical or empirical level, learn the practicalities of being a good clinician (whether formally using hypnosis), and emerge with very valuable hints on how to actualize the many potential clinical benefits of hypnosis.

To students, educators, clinicians, and researchers alike, this is a text that consolidates its reputation as being a classic in its field. Few professionals could emulate its prodigious scope and understanding of the issues and practical work in the field. This is a book that respects the pioneers in the field, looks analytically at the contributions of fresh, innovative people working in the area, provides relevant examples of the points it makes, consistently champions the integrity and rights of clients, and keeps professionals and students alike thinking creatively about what an in-depth understanding of hypnosis can mean to themselves and others.

I recommend *Trancework* unreservedly for anyone looking for a stimulating and pragmatic guide to the field of clinical hypnosis. I am conscious, though, that no one book is ideal for all audiences. This book will suit most, but I think it is especially ideal for clinicians wanting to learn to use hypnosis in their clinical practices. This is Yapko's goal, after all, and he achieves it admirably.

This fourth edition, as did the ones that preceded it, communicates a wonderful enthusiasm for its subject matter. With all that Michael Yapko continues to learn and understand about hypnosis, he becomes even more passionately committed to the field. It shows clearly in the way he continues to write about it. I think every good professional in the area of hypnosis should strive to be like that, but few are ever fortunate enough, like him, to attain that worthy goal.

Peter W. Sheehan, PhD

REFERENCE

Phillips, M. (2003). Endorsement of *Trancework* (3d ed.). New York: Routledge.

INTRODUCTION TO THE FOURTH EDITION

It is my privilege to introduce to you this new fourth edition of *Trancework*. When I first wrote *Trancework* almost 30 years ago, I hoped it would be an enduring textbook to guide professionals in learning hypnosis, one that would be regularly updated to stay current with the dynamic field of hypnosis. That aspiration has been fulfilled. *Trancework* has been translated into other languages and is widely used in clinical hypnosis training programs around the world.

Almost 3 decades later, my life is still powerfully shaped by my dedication to the field of clinical hypnosis. It was not difficult to imagine even back then that hypnosis would grow from primarily being a therapeutic art into a broader science that would offer much to the health-care professions. It has been exciting to watch this gradual transition as hypnosis matured in developing its scientific foundation, and its list of meaningful contributions across many health-care disciplines is ever expanding. Keeping abreast of the goings-on in this fascinating field as it continues to evolve has been a challenge and a delight.

If you are new to the field of clinical hypnosis, I hope you will be impressed and motivated by the many possibilities it offers. To practice and promote a sense of empowerment in people is a core component of effective treatment, and it is inherent in the use of hypnosis. When you utilize hypnosis and your clients find beneficial resources in themselves they never knew were there, the effect is profound. You'll likely discover this relatively quickly once you start working with hypnosis.

If you aren't new to the field, then you have already come to know the merits of hypnosis in clinical practice. What this book will offer you is a comprehensive overview of what's currently going on in the domain of hypnosis, an in-depth consideration of issues associated with the use of hypnosis, a greater

appreciation for the diverse ways in which hypnosis can be applied, and a more detailed description of hypnotic methods and characteristics.

This fourth edition provides a timely update to the field. The previous third edition is now almost a decade old, and enough things have changed to warrant this new edition. You'll note the addition of five entirely new chapters, new sections added to many other chapters, new research citations and updated references, and other changes as well. Carried over from the previous edition but modified in form is *The Case of Vicki*, a dramatic hypnosis session with a 42-year-old woman with terminal cancer. However, to make room for the new chapters without making the book too cumbersome, the transcript of Vicki's session with commentary and analysis was taken from the text and is provided as a download on the publisher's website (go to http://www.routledgementalhealth.com/trancework-9780415884945) to view or download the transcript with commentary and analysis of the Case of Vicki). Also new to this edition is the inclusion of the DVD of the session with Vicki so readers can watch the session and follow along with the transcript as they watch. As you will see, this powerful example of hypnosis applied in one of the most vulnerable of situations warrants the special attention it receives here.

This book is meant to serve as a guide to formal training in clinical hypnosis. As before, at the end of each chapter there are suggestions for things to consider and things to do. These are provided to encourage you to be an active student. After all, the best learning of hypnotic skills comes from doing things proactively to help develop them. I hope you will find these exercises interesting and helpful to your learning process.

I hope you will be inspired by all that I have written here to make hypnosis a core dimension of your clinical work. There is a world of people out there who desperately need the skills you'll be acquiring.

Michael D. Yapko, PhD
www.yapko.com

Access the Case of Vicki at
http://www.routledgementalhealth.com/trancework-9780415884945

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PART I

CONCEPTUAL FRAMEWORK

CHAPTER 1

WHAT IS HYPNOSIS AND CAN IT HELP?

Vicki knew something was physically wrong with her, but she didn't know how wrong. The numerous doctors she presented her symptoms to seemed unconcerned, and she reported that several were even abruptly dismissive of her. She assumed the unwelcome reactions she received from her doctors were probably because her patient file was so thick and included an extensive history of mental health issues. The doctors reasoned, and apparently more than one even said it to her directly, that anyone with such an accumulation of hospitalizations and doctor visits, most of them psychiatric, must be a deeply troubled woman. Presumably, she must be prone to exaggeration at least, or may be a frustrating and time-consuming hypochondriac, or perhaps is even delusional. She rationally countered, "But even hypochondriacs get sick!" and asked for appropriate medical tests. By the time she was finally diagnosed with terminal cancer, it was too late for her to be heard. The cancer had already spread throughout her body and was in her brain, bones, lungs, and adrenals. She was told she had a very short time left to live, probably just weeks. There were no apologies or expressions of regret from her dismissive doctors. All healthcare providers strive to do the best for their patients, but, in Vicki's case, some unfortunate assumptions steered presumably well-meaning physicians away from listening to their patient with tragic consequences. We all make mistakes, but Vicki's case highlights how important it is not only to listen but to truly hear as well.

Vicki had tumors growing in her body that caused her considerable pain at times. She was told by her newly sympathetic doctors that she could have whatever pain medications she might need or want to make her last days comfortable. But Vicki didn't want to take any pain medications

at all, if possible, out of concern they would negatively affect her mentally. She wanted to be as fully alert and physically active as possible for whatever time she might have left. She found her way to me to explore whether it might be possible for her to learn how to use her mind to manage pain without drugs. She had heard that clinical hypnosis was a valuable therapeutic tool that could even be used by patients to undergo major surgeries without the use of any chemical anesthesia. She was informed correctly. Vicki wanted to develop as much control over her pain as she could so she could function as well as possible right up to the very end.

What a remarkable woman—in the face of her impending death, she sought personal growth. Instead of focusing on despair, she chose to focus on increasing her sense of fulfillment. Vicki was inspiring, and I wanted to help her in any way I could. But what could I say to ease her pain? What could I teach her about her inner experiences and hidden resources that would help her manage dying with the kind of comfort, dignity, and clarity she wanted?

By the time we began the hypnosis session, Vicki had revealed many facets of herself that were extraordinary: courage, determination, resilience, focus, and more. All that she had experienced in her life, right up to age 42 when I saw her, had come to serve as powerful personal resources. What hypnosis does best is amplify people's abilities, including their hidden abilities such as the capacity to reduce the subjective experience of pain or the capacity to better adapt to a change in their circumstances. Hypnosis empowers people to discover and develop strengths in themselves they didn't know they had, and the consequences in people's lives are often nothing short of extraordinary.

Hypnosis helped Vicki find the comfort she wanted. The full session with Vicki is available for you to watch on the DVD included with this text. Also, a full transcript of the entire session with Vicki, including commentary and analysis, can be found online. I think you'll find the session a moving example of how hypnosis can be used to make a meaningful difference for someone struggling with issues as deep and powerful as life and death.

The power of hypnosis. The "magic" of hypnosis. The mystery of hypnosis. The danger of hypnosis. The very word has a powerful aura of intrigue associated with it.

What is hypnosis? How is hypnosis relevant to clinical interventions? And how can you begin to acquire the necessary skills for incorporating hypnosis into your clinical practice? These three questions provide the foundation for this text, and multifaceted answers derived from clinical and experimental research will be forthcoming as each chapter unfolds. This book will provide clinicians wanting to learn hypnosis with both perspectives and methods that

are based on current scientific understandings of hypnosis as well as the realities of modern clinical practice.

In this first chapter, I explore in a general way some of the issues that relate to the field of hypnosis:

1. The difficulties in trying to define something as complex as hypnosis
2. The mixed reactions hypnosis receives from people
3. The effectiveness of hypnosis in treatment
4. The importance of the relationship between the therapist and client in the treatment process
5. The hazards of overselling hypnosis
6. The limitations of labeling multidimensional experiences such as hypnosis
7. The roles of communication and influence as foundational to therapeutic experiences in general and hypnotic experiences in particular
8. The merits of developing a strength-based approach to integrating hypnosis into treatment

These topics provide a good introduction to the field and are further developed in subsequent chapters.

A FIRST ATTEMPT TO DEFINE HYPNOSIS (SORT OF)

It makes good sense to want to have a definition of the phenomenon this thick book is all about here at the outset. This is easier said than done, however. Scholars have grappled with the issue from the earliest days of hypnosis. Even longtime practitioners have an easier time describing rather than defining hypnosis. For example, John (Jack) Watkins is a psychologist and one of the earliest pioneers of modern clinical hypnosis. In fact, he was a founding member of the first professional hypnosis society, the Society for Clinical and Experimental Hypnosis, in 1949. He captured the essence of the enigma of hypnosis in a recent article titled "Hypnosis: Seventy Years of Amazement, and Still Don't Know What It Is!" (Watkins, 2009). His inability to define hypnosis after all these years is certainly not for a lack of thoughtful research and consideration. Rather, the lack of a precise definition for all of us in this field speaks to the complexity of trying to untangle the intricacies of hypnosis when it encompasses scores of variables from domains as diverse as neuroscience, social psychology, individual psychology, and genetics. You'll be introduced to many of these variables throughout the book.

Hypnosis has no single agreed upon definition. In an attempt to create one that most experts might accept, Division 30 of the American Psychological Association, called the Society of Psychological Hypnosis, formed a committee of well-known hypnosis experts to develop a definition it hoped "would serve to demystify hypnosis and encourage its use by both consumers and

providers" (Green, Barabasz, Barrett, & Montgomery, 2005, p. 261). Realistically acknowledging that not everyone would agree with this definition, the executive committee of Division 30 accepted the following as the formal definition of hypnosis:

> Hypnosis typically involves an introduction to the procedure during which the subject is told that suggestions for imaginative experiences will be presented. The hypnotic induction is an extended initial suggestion for using one's imagination, and may contain further elaborations of the introduction. A hypnotic procedure is used to encourage and evaluate responses to suggestions. When using hypnosis, one person (the subject) is guided by another (the hypnotist) to respond to suggestions for changes in subjective experience, alterations in perception, sensation, emotion, thought or behavior. Persons can also learn self-hypnosis, which is the act of administering hypnotic procedures on one's own. If the subject responds to hypnotic suggestions, it is generally inferred that hypnosis has been induced. Many believe that hypnotic responses and experiences are characteristic of a hypnotic state. While some think that it is not necessary to use the word "hypnosis" as part of the hypnotic induction, others view it as essential.
>
> Details of hypnotic procedures and suggestions will differ depending on the goals of the practitioner and the purposes of the clinical or research endeavor. Procedures traditionally involve suggestions to relax, though relaxation is not necessary for hypnosis and a wide variety of suggestions can be used including those to become more alert. Suggestions that permit the extent of hypnosis to be assessed by comparing responses to standardized scales can be used in both clinical and research setting. While the majority of individuals are responsive to at least some suggestions, scores on standardized scales range from high to negligible. Traditionally, scores are grouped into low, medium, and high categories. As is the case with other positively-scaled measures of psychological constructs such as attention and awareness, the salience of evidence for having achieved hypnosis increases with the individual's score. (Green et al., 2005, pp. 262–263)

The Division 30 hypnosis definition inspired a great deal of thoughtful dialogue. Stephen Lankton (2005/2006), editor of the *American Journal of Clinical Hypnosis (AJCH)*, invited a number of experts to offer their thoughts and reactions on the subject in the *AJCH*. (See the October 2005–January 2006 issue for these interesting and insightful commentaries.) This broad definition acknowledges the person performing hypnosis, the context in which it is done, and the experience of the person participating in hypnosis. What happens in the mix of these three domains of consideration that makes it possible for individuals to suggest to someone else that they have an experience that, under normal conditions, would seem unlikely? For example, suggesting to people that they have a sense of numbness in a particular physical location is not typical conversation. Something very special is going on in the world of hypnosis, as I hope and expect you will discover here.

Here is my own admittedly imperfect definition of hypnosis: It is a focused experience of attentional absorption that invites people to respond experientially on multiple levels to amplify and utilize their personal resources in a goal-directed fashion. Employed in the clinical context, hypnosis involves paying greater attention to the essential skills of using words and gestures in particular ways to achieve specific therapeutic outcomes, acknowledging and utilizing the many complex personal, interpersonal, and contextual factors that combine in varying degrees to influence client responsiveness.

HOW DO PEOPLE GENERALLY REGARD HYPNOSIS?

Hypnosis tends to receive a mixed reaction from both professionals and the general public; people usually have a great curiosity about hypnosis, but it is often mixed with skepticism and misapprehension based on commonly held misconceptions. These will be discussed in detail in the next chapter.

To help gain acceptance for hypnosis or, more typically, for themselves, some practitioners have made some pretty wild claims, have sensationalized treatment results, and, in general, have built hypnosis up into a seemingly magical process that seems to have everything going for it but a formal endorsement from the Almighty. Unfortunately, the more grandiose a claim for any product or service, the more skeptical the careful consumer must become. The result is almost inevitably more turn-offs than turn-ons.

As hypnosis has increasingly become the subject of serious scientific inquiry, an appropriate scientific modesty has emerged, effectively scaling down grandiose claims while steadily increasing what can legitimately be said in its favor based on substantive evidence. The science of hypnosis is impressive: Thousands of articles have been published in the best of peer-reviewed scientific journals, and membership in the national and international professional societies has encouraged more and more clinicians and researchers to join together to continue to investigate the therapeutic merits of hypnosis.

Hypnosis invites lively discussion, curious speculation, and even profound philosophizing about the nature of human consciousness and the complex, often confusing relationships among mind, body, and spirit. Hypnosis continues to confound a general public that can't readily grasp how it can be used in cheesy stage show routines yet also be taken seriously by prominent researchers and clinicians who unequivocally declare it an effective vehicle of treatment.

I'm encouraged by the fact that more and more frequently I encounter people who have had positive exposure to the applications of clinical hypnosis. Some wonderful segments regarding hypnosis have aired on popular television programs in recent years, some excellent articles describing clinical hypnosis have appeared in popular magazines, and hypnosis has been featured favorably in a variety of other media as well. As a direct result of these and other influences, such as highly respected individuals and institutions promoting its

use, hypnosis has steadily grown in depth and breadth to become an important and more widely utilized member of the health treatment team. There is still a long way to go in making hypnotic principles and methods a part of most helping professionals' repertoire of fundamental skills. But my experience in teaching clinical hypnosis to health professionals of diverse backgrounds and interests suggests that when hypnosis is made a more practical and understandable tool, its positive use grows and the appreciation for its therapeutic merits spreads.

HOW HYPNOSIS INFORMS CLINICAL PRACTICE

This book doesn't seek to sensationalize hypnosis, nor is it intended to make a statement about how hypnosis is "the answer to all of life's challenges." Rather, every attempt is made here to provide an even-handed approach to the subject. My passion for hypnosis will no doubt be evident throughout, but it will be shaped by a sense of responsibility to not go too far beyond what the science tells us. Here, hypnosis is conceptualized and treated as a means of helping clients develop powerful personal resources that can be purposefully directed toward achieving their therapeutic goals. The evidence for the effectiveness of hypnosis is already substantial and ever growing (Alladin, Sabatini, & Amundson, 2007; Barabasz & Watkins, 2005; Lynn, Kirsch, Barabasz, Cardeña, & Patterson, 2000; Moore & Tasso, 2008).

Therapeutic intervention of any type inevitably involves skilled communication between client and clinician. Therapy's *interpersonal* (i.e., social) aspects are a primary focus in studying clinical hypnosis, since a primary question we routinely ask ourselves as clinicians is the one posed in the Vicki vignette: What can I say to ease this person's pain? Studying hypnosis teaches us a great deal about how to present ideas and how to structure interactions for maximum therapeutic benefit.

Just saying something with an intention to be helpful isn't enough, however. How a client hears what we say is an obviously crucial piece of the interaction. The study of hypnosis offers substantial insights into how human beings construct their individual realities and how the various intrapersonal components of human experience can be assembled to help generate wellness at one end of the continuum and pathology at the other (Kihlstrom, 2008; Pintar, 2010a).

Studying hypnosis will no doubt change your understandings of people and their problems by encouraging you to look for client strengths in ways you may not have considered before. Acquiring skills in the use of clinical hypnosis will be an invaluable means for enhancing your clinical abilities. Integrating hypnosis into your treatment plans can allow you to obtain lasting results in the therapy work you do. Perhaps best of all, use of hypnosis can be a way to promote self-sufficiency and independence in the clients you work with, helping them to feel more in control, resourceful, and self-assured.

THE CLINICIAN–CLIENT RELATIONSHIP IS THE FOUNDATION FOR HYPNOSIS

Clinical hypnosis has many different facets, each reflecting a different dimension of the phenomenon. In this book, I primarily pay attention to the clinical context in which hypnosis is applied. By focusing on the clinical use of hypnotic principles and approaches, I pay greater attention to the essential skills of using words and gestures in particular ways to achieve specific therapeutic outcomes. Thus, the emphasis throughout will be on the use of hypnotic processes as agents of therapeutic influence involving patterns of effective relationship and communication skills. This is not to say that hypnosis is only about the skills of the clinician, particularly when it is well established that hypnosis happens only when the client permits it and has the salient resources for it (Hilgard, 1992; Lynn, Kirsch, & Rhue, 2010; Nash, 2008b). But the skills of the clinician are a large part of the hypnosis equation, and these skills are the focus of this book.

The orientation toward hypnosis emphasizing skillful relating to the client minimizes the use of ritualistic or impersonal approaches to hypnosis, instead encouraging an assessment of and flexible responsiveness to individual client needs. Identifying and responding to the unique attributes of each client is considerably more demanding than adopting a "one-size-fits-all" scripted approach and accounts in large part for the considerable effort involved in becoming skilled with hypnosis. I am inclined to say the same thing about developing any clinical skill.

My emphasis throughout generally leans in the direction of being "practical" and "understandable." I present the concepts and techniques of hypnosis in a way that will allow you to evolve clinically useful understandings and methods. In doing so, I strive to avoid, whenever possible, the unanswerable philosophical questions that knowledgeable people have debated about endlessly, such as whether "reality" exists or whether Adam was in hypnosis when God took his rib to make Eve.

THE CHALLENGE OF PEOPLE'S NEGATIVE BIAS ABOUT HYPNOSIS

Most people have seen or heard of hypnosis, and whatever they saw, heard, or felt at the time left an impression as the basis for their attitude. Hypnosis has been demonstrated in movies, kiddie cartoons, television programs, stage shows, state fairs, and night clubs everywhere. You may have seen someone dabble in the art at parties. It may have led someone you know to try to quit smoking in one of those "instant success" programs and feel worse if he or she failed to do so. It may have been thought to be the reason a kid in your

neighborhood joined a cult. With this kind of negative anecdotal exposure, it is little wonder that many people feel certain that whatever hypnosis is it is beyond understanding and probably dangerous.

For stage performers, keeping the mystery in hypnosis means more bread and butter. Unfortunately, these are the people least able to use hypnosis effectively to its greatest potential as a valuable clinical tool for helping people improve their lives. Instead, they misrepresent hypnosis to the public, both layperson and professional, as an apparent mind-controlling instrument with frightening implications. It is difficult to bridge a gap as wide as the one between the crudeness of stage hypnosis and the refined applications of clinical hypnosis.

Few other fields have had the ups and downs hypnosis has had. Historically, acceptability ranged from moderate to none. In the past, people who practiced hypnosis may have had their individual ideas and preferred methods, but they had very little scientific understanding of what they were actually doing. There simply wasn't much scientific insight to be had. The predominant assumption was that there was something inherently powerful about the technique itself; thus too little attention was paid to the inner processes of the client or the nature of the situation in which the hypnosis was applied. With ever-increasing evidence of the effectiveness of hypnosis in catalyzing positive clinical outcomes, and with acceptability and applicability of hypnotic processes growing in scope as a result, the need for a sensible, understandable approach is more necessary than ever for maximizing positive exposure to hypnosis. Helping to provide it is a primary goal of this book.

IS THERE EMPIRICAL EVIDENCE THAT CLINICAL HYPNOSIS REALLY WORKS?

The current climate for clinical practice, and the climate that will likely prevail for the foreseeable future, heavily emphasizes empiricism. Clinicians in all fields are now routinely being asked to explain and justify their methods in terms of objective data attesting to the merits of their interventions. In the practice of psychotherapy, clinicians are expected by insurance companies, employers, and even well-informed clients to use only those methods that have a strong base of support in clinical research. Some in the field have even gone so far as to promote the idea of fully manualizing treatments such that therapy is performed according to a specified format developed on the basis of controlled research indicating its value.

The field of clinical hypnosis has been directly influenced by the push for "empirically supported treatments." In recent years, substantial high-quality research has been done to assess what, if anything, hypnosis can contribute to the positive effects of treatment. Thus, a growing body of good hypnosis

research is becoming available to clinicians of all types, especially since this valuable research is no longer being published only in hypnosis specialty journals.

What does the hypnosis research say about hypnosis as an empirically supported treatment? How should we view such research? These are important questions to consider at the outset of your study of clinical hypnosis. As you evolve your own individual conceptual framework and style for applying hypnotic approaches, you will be better equipped to determine for yourself the significance and relevance of particular research findings for your work.

Let's briefly consider the issue of how to view hypnosis research before discussing general or specific findings. Much more will be said about these issues later, of course, but in this first chapter it seems necessary to address the research issue, even if only superficially. To pose the question directly: Does clinical hypnosis work? That is, is it an effective therapy? The question seems straightforward, as if there should be a clear response. Unfortunately, though, the issue is complicated and precludes a simple reply. The debate continues to this day as to whether hypnosis should be considered a therapy or simply a therapeutic tool but not a therapy in its own right. There are prestigious and persuasive advocates for both positions.

For those who view hypnosis as a therapy in its own right, a therapy that employs hypnosis is commonly termed *hypnotherapy* and thus implies that hypnosis is the principal mechanism of intervention. Hypnosis is viewed by hypnotherapists as a style of treatment that is as well defined and as distinct in character as, say, behavior therapy. On the other side of the issue are those who view hypnosis as a tool of treatment, inevitably integrated into a larger conceptual and practical framework that transcends the hypnotic procedures themselves. Rather than hypnosis or suggestive procedures being "stand-alone" methods, clinical hypnosis is used to further the aims of other, more well-defined interventions, such as cognitive therapy. It may seem like an annoying semantic issue to some, especially in the United States, but in many other countries the issue is substantial because how you define your work determines whether you are eligible for payment from government insurance resources. My own position is that clinical hypnosis is a tool, not a therapy in its own right. I can't help but notice the larger therapeutic framework the hypnosis is inevitably embedded within. The salient question for me, therefore, is not, "How does hypnosis compare to another therapy in treating some condition?" Rather, it is, "If a therapy approach is employed without hypnosis, and hypnosis is added to the same type of intervention, will the addition of the hypnosis increase the effectiveness of the therapy?" The answer to this question is generally yes. Hypnosis generally enhances treatment outcomes.

Whether hypnosis enhances treatment results is not dependent on resolving the issue of whether to define hypnosis as a therapy or a therapy tool. The dividing line between a therapy and a therapy tool in this case is sufficiently ambiguous to arouse debate by the experts. What matters more is the growing body of objective evidence that, when hypnosis is part of the treatment

process, it generally increases the benefits of treatment (Kirsch, Montgomery, & Sapirstein, 1995; Lynn et al., 2000; Moore & Tasso, 2008; Schoenberger, 2000). Clinical hypnosis has been successfully applied across a wide variety of clinical populations suffering from disorders such as anxiety (Mellinger, 2010), depression and depression relapse prevention (Aladdin, 2006, 2010; Yapko, 1992, 2001a, 2001b, 2001c, 2006a, 2006b), posttraumatic stress disorder (Spiegel, 2010), anorexia nervosa (Nash & Baker, 2010), pain (Jensen, 2011a; Patterson, 2010; Patterson, Jensen, & Montgomery, 2010), habit control (Green, 2010; Lynn & Kirsch, 2006), irritable bowel syndrome (Palsson, Turner, Johnson, Burnett, & Whitehead, 2002), headache and migraine (Hammond, 2007), asthma (Brown, 2007), sleep disorders (Graci & Hardie, 2007), cancer (Néron & Stephenson, 2007), psychosomatic disorders (Flammer & Aladdin, 2007), and many other medical and psychological conditions.

Hypnosis can differ dramatically from the way one clinician applies it to the way another clinician applies it. Thus, when one researcher concludes hypnosis did not significantly increase positive effects, or, conversely, when another researcher concludes it did, it bears more careful scrutiny by the reader to determine what kinds of procedures were used and whether they reflected a particular style or orientation to hypnosis that enhanced or diminished the value of the findings.

Thus, the question "Does hypnosis work?" is a complicated question. Is it the hypnosis itself that "works," or is it the larger treatment plan of which hypnosis is only a part that is effective? In the most general sense, though, it can be said with confidence that hypnosis helps improve treatment outcomes. That in itself justifies the time and effort it takes to learn clinical hypnosis.

BUYER BEWARE

It is often incorrectly assumed that whatever I do with hypnosis is similar to whatever anyone and everyone else who uses hypnosis does with it. Few people have had enough exposure to hypnosis to be able to differentiate the types and applications of hypnosis from one another. This is a drawback to being an overt practitioner of therapeutic hypnosis; the general public assumes that "hypnosis is hypnosis is hypnosis," and all they have to do as consumers is shop around to find the most inexpensive deal with the most promises attached.

Used skillfully, however, this problem can become an asset. By exploring the various treatment approaches and possibilities with persons seeking information about my work, I can help them become knowledgeable enough to make meaningful decisions. Helping consumers have the information necessary to make informed decisions about treatment should, in my opinion, be basic to any professional practice. Just because individuals don't ask questions doesn't mean they have none. It usually means they just don't know what to ask.

By involving people in a brief discussion about their needs and the nature of clinical hypnosis as part of the treatment process, one can provide information that helps consumers more realistically assess their needs and the best means for meeting them. Often, formal hypnosis (i.e., a procedure clearly defined as hypnosis) aimed at symptom removal alone is neither a desirable or realistic treatment alternative but was turned to by clients for some presumed "magic" or a chance to avoid pursuing other more personally challenging approaches to treatment.

The fact that hypnosis is often misrepresented in the media contributes to popular stereotypes of hypnosis as a magical means for instant problem resolution. I wish I had a nickel for every person who has asked me for a "quick suggestion" to stop some unwanted behavior. Rational explanations of why the work to be done might be a little more involved than they think are often met with puzzled looks and some variation of the question "Then how does a stage hypnotist just snap his fingers to get his subject to do whatever he wants him to?" Unrealistic concepts can lead to disappointment and disillusionment in clients.

Clarifying the purposes and capacities of hypnosis is almost always beneficial for clients. If the unusual situation arises where it may be of benefit to them to not be directly active in treatment, they might choose not to hold an informative discussion, occasionally an appropriate alternative. Clarification, however, leads them to face the fact that there will likely be no miracle cures other than the ones they provide for themselves. It means both accepting personal responsibility for the problem and being active in its resolution.

Almost as dangerous as the stage hypnotist in promoting misconception, perhaps even more so, is the hypnotist who, through ignorance or greed, uses hypnosis in a practice that caters to public misconception. Such people usually have little or no formal education in hypnosis and the clinical sciences but know just enough to mislead people with claims of sensational power.

These are just a few of the challenges faced by hypnosis as a field in its quest for greater visibility and appreciation. Others are discussed in later sections of the book. The point is made throughout that if hypnosis is to be considered a serious treatment alternative, it must be promoted with a sensitivity to the issues of concern both to consumers and other health-care providers.

BROADENING PERSPECTIVES ABOUT HYPNOSIS

Labeling Experiences

Sometimes when people try to describe or define an experience, attaching a specific label to the experience limits the way the experience will be perceived. For example, if a new coworker is introduced to you as a patient recently released from a psychiatric unit, how will your perception of the person be

influenced by the label *psychiatric patient*? Would you react to the person in the same way if no such introduction was given?

When you consider a simple, concrete object, such as a chair, the tendency for labels to bias you and get in the way of open-minded experience is not so troublesome. The word *chair* represents something tangible that most people can experience similarly. In considering something as abstract, complex, and subjective as *hypnosis*, however, the difficulties arise almost immediately. The word represents different experiences to different people, literally preventing the attainment of a precise shared meaning.

Historically, hypnosis has been considered a subjective *state* of experience ("in hypnosis") in which individuals have capabilities or experiences generally regarded as atypical of the "normal waking" state (Kirsch, 2011). Hypnosis has also been considered a *process* ("doing hypnosis") in which a hypnotist offers suggestions to a subject or client (Weitzenhoffer, 2000). Both of these concepts are correct, yet both are limited in using the word *hypnosis* to describe an individual, subjective state and also a process of offering suggestions to another person.

Hypnosis as a word has been overused to the point of robbing it of any real meaning. When one word comes to describe as many different experiences as hypnosis has, there is ample opportunity for misunderstanding, mislabeling, misconception, and ultimately confusion. As a direct result, the field of hypnosis is internally divided, much as the field of psychotherapy is internally divided (Kihlstrom, 1997, 2008; McConkey, 2008). Different practitioners and researchers each tend to emphasize a different facet of hypnosis in striving to explain it. While each viewpoint adds to our understandings of the phenomenon, it also frustrates efforts to achieve a unity within the field.

Because hypnosis is one word for many different kinds of experiences, most people's exposure to hypnosis remains quite general. The average person is led to believe that "hypnosis is hypnosis," regardless of context. Furthermore, because the word *hypnosis* is used for many different experiences, even helping professionals untrained in hypnosis are skeptical about its use in clinical contexts, uncertain whether it differs appreciably from the silliness demonstrated in stage shows. As you will learn, though, the context in which hypnosis is applied is ultimately what defines it and gives it substance.

Proponents of hypnosis have long recognized the difficulties in getting people to be open to its clinical use when their previous exposure to hypnosis has been only to the stage variety. Some have even tried to rename hypnosis with more scientific-sounding names, yet the term *hypnosis* remains virtually unchanged in common usage. It seems imperative to be clear in describing the clinical context in which hypnosis is used so others may be continually reminded of the variety of applications. Thus, *clinical hypnosis* is preferable to *hypnosis*, and *medical hypnosis* is even more descriptive than *clinical hypnosis*.

COMMUNICATION AS A CONCEPTUAL FRAMEWORK FOR HYPNOSIS

Is there any compelling reason to adopt a single theoretical framework for understanding and applying clinical hypnosis? How do we distinguish between our own conceptual or philosophical framework and the actual experience of the client? The hazard is in not seeing phenomena that lie outside the boundaries of what we tend to look for. The fact that most clinicians describe themselves as eclectic in orientation is an indirect statement by professionals that they want to have the freedom to do what is effective, independent of an allegiance to one specific model of intervention.

It becomes possible to transcend hypothetical considerations of the structure of the mind or personality when you consider how you detect such structures. In other words, if there are detectable structures of the mind and personality that can be recognized and developed into explicit theories or models, perhaps the level of consideration that is most worthwhile to study is the means by which such structures are evidenced in the person. What exactly do clients say or do that reveals the presence of these hypothetical structures to a clinician? The person somehow communicates them. By focusing on clients' communications, the clinician can come to better understand something of their subjective experience and can therefore strive to better understand what aspects of experience need attention and intervention.

Every person who works with people in a clinical capacity makes continuous assessments of clients' needs, motivations, skills, and limitations (Lynn & Kirsch, 2006). Each further assesses the likelihood of success in reaching the goals of their relationship. These assessments are made in a variety of ways, not the least of which is in accordance with how the clinician chooses to conceptualize the problem from the way it is communicated, that is, the framework he or she uses to organize perceptions while working with the client.

Your clinical framework is your way of viewing people and their problems. It varies from clinician to clinician according to formal training, personal experience, and the resulting belief system arising from the interaction of the two. Someone who believes in one particular theory will conceptualize a problem's dynamics differently from someone else who believes in and practices from a different theory. For example, someone with a weight problem will be given different alternatives and instructed in different concepts while undergoing cognitive-behavioral treatment than will someone undergoing treatment for the same problem while undergoing psychoanalysis. Likewise, a 12-step approach to the weight problem will be substantially different in structure from a medical approach.

No one theory to date adequately explains why people do what they do or how to intervene therapeutically in a uniformly successful way. There are hundreds of psychotherapies currently in use (Hubble, Duncan, & Miller, 1999).

Each has its advocates, and each has at least anecdotal support in the literature. Despite the wide array of approaches for providing treatment, no therapist succeeds with all clients, perhaps not even with most. Psychotherapy is able to help people, but it is not 100% effective, nor is it ever likely to be, given the varied and unpredictable nature of human beings. The idealistic goal is to learn its limitations and strive to transcend them.

This, then, is my point: It seems that taking clients' communications about their problems and altering them from their original form to fit with some preferred theoretical belief is a step that is both arbitrary and unnecessary. Responding to clients' communications in their original form as a reflection of what they are experiencing can lead you to communicate in a more meaningful way that can enhance the quality of the interaction.

The approach to clinical hypnosis promoted in this book is essentially a way of organizing your therapeutic communications to best fit an individual's needs, using words and gestures selectively to arrive at some worthwhile outcome. Which therapeutic framework you choose to work from is not an issue here. All the therapeutic approaches work some time with somebody, which is why each has devotees. The clinical skill lies in knowing which approach to use with someone at any given moment.

Clients who sense being understood by the clinician are more likely to benefit from the relationship. Of course, this is not an original idea, for every clinician is trained to appreciate the importance of the quality of the relationship with the client. Literature in hypnosis and psychotherapy generally employs the terms *rapport* and *therapeutic alliance* to describe the ideal positive interrelationship between hypnotist/clinician and client. How one attained rapport or built the therapeutic alliance was left up to the individual clinician, as it must be.

The process of clinical intervention can reasonably be described as a series of communications between a clinician and client. No matter what your orientation, you are using the communications of the client to make assessments, and you are using communications as the vehicle for delivering your therapy. A therapeutic communication is defined as one that influences the person in distress to think, feel, or behave differently in a way that is considered more adaptive or beneficial. In producing a beneficial result, the client's experience matters, the clinician's skills matter, and the relationship between them and the context in which they interact matter.

To use your words and gestures skillfully in the deliberate creation of therapeutic experiences for an individual in distress (or any other person one would want a specific outcome with) is the "nuts and bolts" of what hypnosis is all about. Approaching hypnosis from this standpoint places emphasis on being an effective communicator, one who is able to recognize and competently relate and respond meaningfully to the communications of others.

When you shift the focus away from mere techniques to consider dimensions of communication that increase the potential for influencing another person's experience, the emphasis is much less on ritual or attaining particular levels or depths of hypnosis and much more on the use of words and gestures in specific ways. Thus, elements of any piece of communication can have hypnotic qualities associated with them without formally being called hypnosis (Barber, 1969; Watzlawick, 1985; Zeig & Rennick, 1991). Simply put, you don't have to incorporate the rituals of hypnosis to be hypnotic in your wording or demeanor. Even if you were to choose not to pursue expertise in doing formal hypnosis in your clinical practice, you can still benefit greatly from learning about the power of effective communication through the study of hypnotic approaches.

Influence Is Inevitable

Too often, clinicians see themselves as functionally separate from their interactions with their clients. They may think they can ask questions without influencing the quality of the answers they get, or they may think they can be neutral in avoiding offering direct advice when asked for some. There are even those who genuinely believe that when they do hypnosis with someone they are simply eliciting—not directing—the client's hypnotic talents. They do not see themselves as playing a significant role in what surfaces at all. This poses a dilemma with potentially serious consequences, for how can you use your clinical skills deliberately and with integrity if you deny you have any influence on what happens?

It is an important starting point in studying clinical hypnosis to recognize the ever-present nature of interpersonal influence. In studying the fascinating realm of social psychology in particular, you learn almost right away that influence is inevitable simply by your being there. Think about this statement: "You will do things when you are by yourself that you will not do if even one other person is around." The mere presence of another person alters your behavior. It is not a question of whether you will influence your client—you undoubtedly will—but rather a question of how much and in what way you will influence him or her. Learning to use patterns of influence responsibly while respecting the integrity of those we work with is a demanding challenge. After all, an insensitively used word can hinder or prevent a positive treatment result. Likewise, a sensitively used phrase can engender a positive belief that dramatically improves the chances for a successful treatment outcome (Lynn & Kirsch, 2006).

Patterns of influence do not just exist in the contexts of therapy or hypnosis, though. If you are observant, you will see them literally everywhere you see social interaction. When you learn to recognize hypnotic elements in everyday situations, especially the power of focus, it will help you to use hypnosis more naturally, flexibly, and with greater success.

HYPNOSIS AND POSITIVE PSYCHOLOGY: A SHARED FOCUS ON PERSONAL STRENGTHS

There is a growing movement in the field of psychology, largely catalyzed by Martin E. P. Seligman, noted researcher and former president of the American Psychological Association. Seligman challenged the field to focus less on the pathologies of humankind and to focus more on increasing its strengths, such as loyalty, compassion, and generosity. Seligman called for the development of what has come to be called a "positive psychology," whose mission would be to research, characterize, and teach those principles that lead to better adjusted individuals, communities, and institutions (Seligman, 2002; Seligman & Csikszentmihalyi, 2000).

Seligman did not originate the concept of studying what's right with people. Significant luminaries like Milton H. Erickson, Abraham Maslow, Virginia Satir, and Carl Rogers all called for developing a deeper understanding of the best parts of human experience. But Seligman has been particularly effective in turning an abstract goal into a domain of well-defined research that has the potential to offer much more than inspiration alone. Indeed, it is already yielding insights into and methods of enhancing peoples' mood, health, and resiliency (Seligman, 2011).

THE FIRST LESSON OF HYPNOSIS: WHAT YOU FOCUS ON YOU AMPLIFY IN YOUR AWARENESS

The very first thing to understand about hypnosis, whether experiencing hypnosis yourself or guiding someone else through the process, is that when you focus on something you amplify it in your awareness (Gendlin, 1981, 1997; Polster & Polster, 1973). If you do cognitive therapy, you tend to focus more on people's thoughts than on other aspects of their experience. If you do behavior therapy, you are likely to focus more on behavior. If you prescribe medication, you naturally focus more on physiology. Key considerations in doing therapy are determining what dimensions of individuals' experience you want to amplify in their awareness and why you want to amplify it. If I'm going to ask you, "So, how do you feel about that?" and thereby encourage you to focus on and amplify your feelings, is there a sound therapeutic rationale for doing so, or am I just asking a routine question out of habit?

The field of hypnosis has largely been a field of positive psychology almost from the start. Hypnosis generally focuses on and amplifies people's strengths and so overlaps greatly with positive psychology both in philosophy and approach. (This overlap will be explored in depth in Chapter 12.) Hypnosis begins with the premise that clients have valuable abilities that are present but hidden, abilities that can be uncovered and used in a deliberate way to overcome symptoms and problems (Lankton, 2001; Yapko, 2001c). When a

clinician helps clients to discover the ability to manage pain without drugs, to discover the ability to move comfortably through situations that used to cause panic, or to develop the ability to shift their focus onto more of what's right instead of only what's wrong and reduces their despair in the process, the clinician is connecting with and enhancing the strongest and healthiest parts of those clients (Lankton & Lankton, 1983; Barber, 1991). Can you focus on symptoms and address the negative factors in people's lives? Of course, and to be therapeutic you have to, at least some of the time. But the greater issue is one of how your beliefs and methods serve to increase or decrease your chances of noticing and amplifying what's right with people.

Is the goal of treatment to reduce pathology or to expand wellness? How you answer this question will help determine much of your reaction to the material in this book and will shape how you ultimately use clinical hypnosis in your own practice. Whatever your answer may be right now, though, I hope your study of hypnosis will gradually highlight for you the value of evolving a strength-based framework that can help inform your understandings of yourself and the people you treat.

FOR DISCUSSION

1. Why do you want to learn clinical hypnosis? What do you find appealing about hypnosis?
2. What is the range of things you have heard are possible to do with hypnosis? What is your reaction to these claims?
3. What previous exposure have you personally had to hypnosis? What were the circumstances, and what were the outcomes?
4. Do you think the use of hypnosis should be restricted in some way, such as by qualified doctors or therapists only? Why or why not? If you think it should, how would you recommend it be done?
5. What things, if any, are you apprehensive about in learning clinical hypnosis? What is the basis for your apprehensions?
6. What skills do you think makes one an effective communicator?
7. What is your general belief system about why people do the things they do? How might your beliefs both help and hurt your ability to interact with others?
8. How do you predetermine what a person is capable of doing? For example, how do you decide whether someone is capable of changing some troublesome behavior?
9. What is your definition of *rapport*? How do you know when you have rapport with someone?
10. Why do definitions of abstract terms, such as *love*, differ so much from person to person? What are the implications for effective communications?

THINGS TO DO

1. Watch the media for stories on hypnosis. How is it represented? Keep a scrapbook of articles that appear over the next few months as you study hypnosis.
2. Interview a variety of health professionals (e.g., physicians, dentists, psychologists) about their attitudes toward hypnosis. What do you discover?
3. Go through the Yellow Pages listings under "Hypnotism," or simply Google the word *hypnosis*. Are there unrealistic or exaggerated claims made for what hypnosis can do? How do you react to these claims?
4. Give your discussion partner instructions not to communicate for 3 minutes while you observe. Does your partner communicate anything to you in spite of your instructions? What? Why is it not possible to prevent communication?
5. List and define the basic constructs of personality from your perspective. How specifically do you become aware of these constructs in the people you interact with?
6. List those people closest to you whom you influence. How do you do so? Do you influence them in ways you would like to?

CHAPTER 2

THE MYTHS ABOUT HYPNOSIS AND A DOSE OF REALITY

The interpersonal process of clinical hypnosis can be viewed as a complex interaction in which the qualities of your relationship and communications with your client help determine their eventual worth in treatment. As a clinician, you use hypnosis to focus clients on important aspects of their experience that can serve as helpful resources, and you introduce to them what you hope and expect will be helpful possibilities (e.g., new ideas, helpful skills).

By describing the hypnotic interaction in broader social terms of communication and influence, much of the mystery of "hypnotic power" can be minimized. The more we learn about what makes for good clinical hypnosis, the more we come to recognize that the important skills to have as a good hypnotist are the same ones needed to be an effective clinician. These include an ability to establish a strong therapeutic alliance and positive expectations for treatment; effective problem-solving skills; flexibility and willingness to experiment with new ideas, perceptions, and behaviors; and many other equally important abilities (Haley, 1973; Hubble, Duncan, & Miller, 1999; Kirsch, 1990a).

SETTING THE STAGE FOR WELL-INFORMED CLINICAL HYPNOSIS

The tendency of people who have previous knowledge or experience with hypnosis is to assume what they already know is accurate. People do not

know they may be misinformed until their existing information and beliefs come into direct conflict with some new information. The clinical implication of this point is that it is especially important to spend time with clients discussing their views and expectations about the therapeutic relationship in general and hypnosis in particular. Gibbons and Lynn (2010) called this the *preinduction talk* and emphasized that since clients' expectations largely define their responsiveness to hypnotic procedures the preinduction talk may be more important than the induction itself. Nash (2008b) similarly emphasized the importance of what he called the *prehypnosis interview* for two primary reasons: "First, the therapist needs to be very clear on the patient's expectations and motivations regarding hypnosis. Second, the lay literature and the mass media are saturated with misinformation about hypnosis. Hence there is often a need to disabuse patients of some of these misconceptions" (p. 488). Thus, it is a sensible practice to discuss what the treatment options are, why hypnosis is deemed an appropriate and recommended treatment, and how the client perceives the information and recommendations. Only through such discussion can a clinician discover the client's expectations, needs, and wishes to assess whether they are realistic and to then evolve a means for using them in the therapy (Lynn, Kirsch, & Rhue, 2010; Voit & Delaney, 2004).

EXPLORING WHAT THE CLIENT BELIEVES AND DEALING WITH MISINFORMATION

In the practice of clinical hypnosis, the opportunity for dealing with misinformation is constant. Most misconceptions people hold are predictable, which can make their identification and rebuttal easier. The single most common misperception that people seem to hold is that hypnosis is a powerful form of mind control in which the hypnotized person has no free will. Most of the other common misconceptions are based on that erroneous notion of surrendering one's will (Gfeller & Gorassini, 2010; Nash, 2008a).

It is difficult to change people's thinking when they are convinced they are knowledgeable in their opinions. In fact, the more knowledgeable people view themselves, the more difficult it is to introduce conflicting information (Tavris & Aronson, 2007). In general, people ignore contradictions or twist them around until everything they believe fits together comfortably, even if incorrectly. Telling some people about the therapeutic value of clinical hypnosis is difficult when their prejudices prevent them from listening. With many people, unfortunately, the predominant attitude is, "Don't bother me with the facts; my mind is already made up." Too often, the client is the one who loses a valuable opportunity for improvement.

Involving clients in a direct discussion about their beliefs and expectations for the hypnotic and psychotherapeutic experience is necessary to make

certain they are knowledgeable enough to make sensible treatment decisions. Since clients' understanding of the therapy process may be inaccurate, incomplete, or both, the ethical and competent professional can provide them with as much accurate information as they may require to be fully involved in the process in a cooperative and positive way. You may note that I say that as much information should be provided as they "require," implying that on some occasions the amount of information dispensed may be marginal while in other instances substantial. Individual client needs differ, and only by communicating clearly with them will you discover their needs. Generally, though, well-informed clients are in a better position to make therapy a more meaningful collaboration.

Many clinicians are helpful in reaction to questions and concerns clients raise, but this may be only a portion of what is required for them to be positively involved in the treatment. Sometimes clients are too self-conscious to ask questions of the clinician, and the risk of seeming ignorant in addition to experiencing problems in need of professional help is too great for some to take. They silently hope the clinician can read minds and effect a cure with as little self-disclosure and involvement as possible on their part. Furthermore, many people simply don't know what to ask, especially if hypnosis is something totally new to them. Only a gentle inquiry will help you decide what individuals might need or want to know.

The hazard of not giving clients enough information is matched by the hazard of giving them too much information when they are not ready for or wanting it. A favorite story illustrates the point: A 6-year-old boy came home from one of his first days at school and with an aura of great intensity asked his mother, "Mommy, where did I come from?" The mother winced, took a deep sigh, and said, "Well, I hoped we wouldn't have to have this talk for a few more years yet, but since you've asked I suppose I should follow the advice of the experts who say if you're old enough to ask you're old enough to know." The mother proceeded to explain the "facts of life" in vivid detail, describing anatomical differences between males and females, the process of intercourse, the fertilization process, pregnancy, and finally the birth process. The little boy sat unmoving and wide-eyed while listening to his mother. Finally, she finished her explanation and asked her son, "So, does that answer your question?" The boy replied, "No, Mommy, it doesn't. My friend Mitchell says he comes from Detroit. Where did I come from?"

In exploring what the client believes about hypnosis, some basic questions that can be useful to ask are, Have you ever had experience with hypnosis before? Was it personal experience, or was it something you saw, read, or heard about? What impression did you form? Since you've requested hypnosis, what leads you to believe it might be helpful to you?

If clients have had personal experience with hypnosis, good questions to ask might include, What was the situation in which you experienced hypnosis?

Who was the hypnotist, and what were his or her qualifications? What was the explanation given to you about hypnosis at the time? What was the specific technique used with you? Was it helpful? Why or why not? How did you feel about the experience? What is the basis for seeking further experience with hypnosis? Such information will be vital in helping determine your approach. However, asking a lot of questions can be threatening and tiresome to clients and so must be done gently.

If individuals have not had personal experience with hypnosis, good questions to ask might include, What is the basis for you requesting hypnosis? How have you heard hypnosis may be applied that is relevant to your concerns? Do you know anyone personally who has experienced hypnosis? If so, what did he or she tell you about it? What is your understanding of how hypnosis works? How specifically do you believe it might be helpful to you as an individual? Have you seen hypnosis demonstrated? If so, in what context? In asking some or all of these questions, you can elicit clients' experiences and attitudes concerning hypnosis. Misconceptions can be dealt with, unrealistic fears and magical wishes can be alleviated, and a positive belief system engendering sensible participation can be established (Argast, Landis, & Carrell, 2001).

Asking about specific hypnotic techniques clients may have previously experienced is very important. If they experienced a process that was ineffective or even unpleasant, then using a similar technique almost guarantees a similar failure. Unless you specifically ask about prior experience, you run the risk of duplicating past negative experiences. Why? Clients' associations to that approach are negative. If you want to create a positive experience with clinical hypnosis, it makes good sense to do something substantially different.

If clients have not had personal experience with hypnosis before but are only indirectly familiar with it through entertainment media or the experiences of an acquaintance, it becomes even more important to discover their beliefs and attitudes. Second- and thirdhand stories about hypnosis from "knowledgeable" friends have a tendency to get distorted and can sometimes be as misleading as the entertainer's version of hypnosis. Many clients who seek hypnosis are fearful of the "mind-control" potential but seek the associated "magic wand" for the "instant results" they've been told are possible. "Instant results" from single session interventions are sometimes possible, in fact, but the larger issue here is to help unrealistic people avoid the "magical thinking" that complex problems can be solved instantaneously through hypnosis.

The Issue of Control

If someone were to come to you, take you by the hand, and say, "Come with me," would you go? Or would you first demand to know where you are being taken? Try this simple exercise on a number of people you know in varying degrees of closeness. It should highlight to you the point that different people respond differently to direction and uncertainty, an important observation

relevant to doing clinical hypnosis. The issue of "control" is readily apparent in such instances.

Clients' fear of losing control of themselves is the single greatest obstacle you are likely to encounter in your practice. In one form or another, almost every common misconception is grounded in this fear. Unless you acknowledge and deal with it in a sensitive and positive way, it will undoubtedly hinder or even prevent the attainment of therapeutic results.

Stage hypnosis and variations of it found in the entertainment media seem to be the biggest culprits for making control an issue of such huge proportions. (See Barrett, 2010a; Pintar, 2010b for detailed reviews of the ways hypnosis has been represented and misrepresented in the media.) The typical viewer of a stage hypnosis show has no idea how the hypnotist can "make" seemingly normal volunteers do all those strange and silly things before an audience. The erroneous conclusion is that the hypnotist has some mysterious power that can make people do things they would not ordinarily do.

The Secrets of Stage Hypnosis

How stage hypnotists get their subjects to perform is easy to understand if you have an appreciation both of hypnotic principles and of certain aspects of human behavior perhaps best described in the literature of social psychology. Let's consider how it is done.

Stage shows formally begin with a call for volunteers, people told to come up on the stage only if they "truly want to be hypnotized." Some stage hypnotists are so well known that volunteers eagerly make themselves available as soon as the opportunity arises, literally rushing to the stage to offer themselves. When stage hypnotists get volunteers, they know several things about these people with a high level of certainty:

1. They are aware of what they are volunteering for and thus are probably willing to perform as directed. There is an exception to this discussed shortly.
2. A general trait common to volunteer performers is some degree of exhibitionism; the greater the degree, the more useful the subject. Someone shy and introverted is unlikely to go on stage to perform before a crowd. If someone shy were to go on stage, one of two things would probably occur: Either the person would "let loose" and consider hypnosis responsible for his or her behavior, or the person would fail the hypnotist's tests for determining subject acceptability and be returned to the audience. For the most part, however, the people who go on stage to become a part of the show are fully aware of what their role requires of them and are agreeable to carry out those demands. You may notice my use of the word *role*. There is a well-defined script the hypnotist creates for the volunteer subject to

follow, even though to the members of the audience it all seems so spontaneous. It's why the faces and names of hypnotic subjects but not the routines themselves change from show to show.

3. Experienced stage hypnotists also know that some individuals are volunteering to participate with the "hidden agenda" of proving to them that they are not omnipotent. Others are intent on proving to themselves that their personal will is strong, evidenced by the inability of the hypnotist to "control" them. Insecure people may have their fragile self-esteem temporarily boosted by an inability to be hypnotized if they interpret it as "having too strong a will" to be controlled by the hypnotist.

To distinguish which subjects are entertaining performers from those intent on "proving themselves" through noncooperative behavior, hypnotists next administer a series of structured hypnotic suggestibility tests to the group of volunteers. This may be done offstage while the audience waits or may be done onstage with the lights dimmed so the audience isn't privy to the testing or the conditioning process of the volunteers. Suggestibility tests are discussed in greater detail in Chapter 14 but are defined here simply as brief hypnotic interactions that can reveal the degree to which the subject will likely respond to the hypnotist's suggestions. Stage hypnotists do a focusing technique or induction and then offer suggestions of specific feelings and behaviors, such as, "You can try but you'll find you can't open your eyes." The most responsive subjects are kept onstage to be used in the show, while the others are told to return to their seats in the audience. Typically, hypnotists offer an indirect suggestion to those remaining onstage about how good and responsive they are as subjects by stating directly to those dismissed from the stage how unfortunate it is that they were not open, secure, or smart enough to succeed as hypnotic subjects. What does that kind of public insult do to rejected persons' self-esteem? One can't be certain, but nothing positive seems possible from such an interaction.

At this point, where the subjects have now been chosen, the pressure to perform intensifies. The subjects have been chosen for whatever qualities (primarily obedience) they possess that will help put on a good show. There is a great deal of pressure to meet the expectations of the hypnotist, the expectations of the crowd, and, not least, themselves. The pressure is to be successful, and success in this context is directly proportional to the level of obedience displayed. Now that the subjects have been chosen and motivated to obey, the show can go on. From the perspective of the audience, the show is ready to begin, but from the hypnotists' perspective, the work for the night is essentially over: Subjects have been properly conditioned to comply, and now the show becomes a matter of simply running them through "tricks."

Hypnotists have cultivated almost unquestioned cooperation in the subject by running persons through tests and then "passing" them, in essence telling

them, "You are the person I want here because I know you will do as I suggest." The literature of social psychology calls attention to how much more valuable a position of membership or a relationship is viewed by individuals if it is difficult for them to attain it. Being accepted as a demonstration subject is a position you have to earn. It is not one given charitably.

The audience expects hypnotic subjects to behave in particular ways, just as the subjects themselves know they will be "made" to act in certain entertaining ways. When a group of people have an expectation of how they are supposed to act, a temporary social norm is established. Deviation from a norm in almost any situation is generally undesirable, and the strong sense of independence it takes not to conform to the norm (the expected behavior) in the stage show context is virtually absent in the chosen subjects. Research on the need for peer approval and its relationship to conformity, discussed in greater detail in Chapter 8, describes this phenomenon clearly (Bordens & Horowitz, 2002). Thus, conforming behavior to get hypnotist and audience approval is a major ingredient in the stage show formula.

In a situation like a hypnosis stage show, where subjects are confident they will not be injured, being the center of attention and the source of a large group's amusement may be reward enough to justify complying with the hypnotist's suggestions. Any negative side effects (e.g., embarrassment, self-recriminations) from the performance can be readily attributed to the hypnosis and not to the subjects themselves. Does the potential for harm to the volunteers exist in stage shows? Unequivocally, the answer is yes. As Heap (2008) pointed out, "Some suggestions may direct a participant to enact or imagine events or situations that would, if they were real, be frightening or distressing for him or her. Moreover, a stage hypnotist cannot be aware of all those things that a participant finds upsetting" (p. 752).

Research consistently shows that people are far more willing to take risks, to exercise questionable judgment, and even to hurt others when they are not held accountable for their actions. Hypnosis is made the culprit for silly behavior, and the subject is free to act "as if" out of personal control. It is to the hypnotist's advantage to maintain this illusion, for if subjects appear to not be maintaining personal control, then it must be the hypnotist who is in control of the subject. This conclusion on the part of the audience is the very perception of having special power the hypnotist strives to foster. It's all a part of the act, and it is very convincing for most people.

Last, but not least, the expectations subjects have toward themselves are involved in this process. Smart hypnotists use subjects' desire for a positive self-image by making it contingent on carrying out the suggestions. Essentially, they say, "Smart (secure, strong, successful …) people respond in this way to this suggestion. Now, how are you going to respond?" Unless subjects want to be viewed by themselves and others negatively, they will likely respond in the suggested manner. People generally want to succeed, not fail; in this context, success is defined as following the hypnotist's suggestions to the letter.

Competent stage hypnotists, before giving any suggestions at all, know that if all the pressures to perform are developed carefully and used properly, subjects will likely be most cooperative. If the pressures to perform have not been developed and used well or if a suggestion is perceived by subjects as too threatening to carry out, the subjects are unlikely to respond as well to the hypnotist.

The structure of the suggestions given to stage show subjects is another factor in the apparent ease with which hypnotists seem to control their subjects. The typical layperson in the audience does not understand how saying, "You wouldn't forget your name, would you?" can induce someone to forget her name. This is an example of "indirect negative suggestion," which carries the hypnotist's requests in a more subtle form but is recognizable all the same. Suggestions for an inability to remember being hypnotized (i.e., amnesia) are typically given in the same covert way, furthering the illusion that the hypnotist has control of the subject's mind. Despite the illusion to the contrary, at all times subjects are fully able to refuse suggestions should they choose to do so. Given the great amount of personal and situational pressure to accept them, however, this capacity is rarely used.

Stage hypnotists are, as a group, skilled in their use of hypnosis. In fact, many of the principles and techniques of stage hypnosis are nearly identical to those of clinical hypnosis. Only the application is different. I can respect their skills and knowledge in hypnosis, but I must admit I have strong negative feelings about their chosen application. Using something potentially beneficial to people in a misleading and even degrading way seems unethical and I believe should be discouraged. Many people who could benefit from hypnosis and many clinicians who could use hypnosis to help their clients will not seek out hypnosis as a therapeutic alternative. They cannot even begin to comprehend how what they have seen in a night club show can be used clinically to help someone in distress, and they just don't want to carry the "baggage" of hypnosis into their therapies.

Some professionals have an opposing viewpoint, suggesting that many people seek out hypnosis in therapy because of the stage hypnotist. That may well be true, but such people are more likely to believe that hypnotists have mysterious powers. So they approach treatment unrealistically, an undesirable consequence. Stage hypnosis and its negative connotations rob good people in need of help of what could be a valuable choice as a treatment alternative by promoting misconception and mystery or even causing direct harm in the name of entertainment. For me, the entertainment value is entirely lost as a result.

Having a good understanding of how stage hypnosis works will be invaluable to you in dealing with the general public's fears and doubts about hypnosis. Addressing misconceptions directly is the subject of the next major section of this chapter.

RESPONDING TO MISCONCEPTIONS

Taking the time to identify and correct misconceptions can help your client build more positive and realistic expectations for hypnosis. It's particularly helpful to emphasize the natural qualities of hypnosis through the use of common examples taken directly from clients' everyday experience, such as driving while absorbed in thought or getting deeply immersed in imagination. Such common examples reinforce the virtually total self-control the person maintains during hypnosis.

If clients fear an imminent loss of control, the typical result is a "power struggle" with the clinician. Would you want to be hypnotized if you thought you would lose control of yourself? The sensible goal in therapy is to do all you can to avoid a power struggle and define the relationship as a cooperative one. After all, there is really no way to win a power struggle with clients. To defeat your very best efforts, all they have to do is nothing.

The Power to Choose

Using the power struggle as well as any other interpersonal factors that arise as a hypnotic device to enhance the therapy is possible when you recognize the paradox present in hypnosis and psychotherapy. Family therapy pioneer and hypnosis expert Jay Haley (1963) described this paradox in terms of the hypnotist's seemingly contradictory messages: "I can hypnotize you only by you hypnotizing yourself; I can help you only by you helping yourself." Essentially, the message emphasizes the responsibility and control on the part of the client yet acknowledges that it is shared with the clinician. If I say to you, "Here—I'm giving you control of me," then who really is in control of me? If I have the control to give you control, then all I am doing is suspending my capacity to choose. I remain free, though, to begin making choices again anytime I have to or want to.

Clients in hypnosis are free to overtly or covertly reject suggestions that don't fit for whatever reason. So, even though clients seem to be saying, "Control me," clinicians can appreciate that control of clients is not theirs to assume. Rather, the responsibility of the clinician is to structure suggestions responsibly and competently to maximize the likelihood that they will be accepted and translated into a therapeutic change. However, there is never a guarantee that even the most well-formed suggestion will be accepted and acted upon. Therapist skill only increases the probability.

The role of choice in the hypnotic encounter cannot be overemphasized. Hypnosis has occasionally been accused of making good people do bad things, but such accusations do not consider realistically the choices individuals made—or didn't make, which is also a choice. At any given time, persons

in hypnosis are in a position to choose to lighten, deepen, maintain, or end the experience.

WHAT ABOUT THE OTHER SIDE OF THE CONTROL ISSUE?

Teaching hypnosis to many health-care professionals over many years has led me to realize that students of hypnosis confront the issue of control from an opposite perspective. If typical clients are fearful of being controlled, it is easy to appreciate how the misinformed clinician can be fearful of being the "controller" and having an awesome responsibility (Barber, 1995).

Typically, those entering their first course in clinical hypnosis are intrigued and excited by the potential applications of hypnotic phenomena. There is usually also an appropriate sense of concern, even fear, they will be developing powers they might "lose control" of to someone else's detriment. Developing skills in clinical hypnosis presupposes taking responsibility for initiating and guiding the course of therapy, so there arises for some students the issue of how they will deal with the "power" they think they will obtain from studying hypnosis. For some, the ability to direct another person's experience is used in self-serving ways, evidenced in arbitrary demonstrations of illusory power by requiring the "subject" to respond to such degrading things as finger-snaps. Usually, I become aware of the concerns in a more positive way, however, when students express their thoughts and feelings about developing hypnotic skills in the course of training.

Actual experience with hypnosis will demonstrate to you quickly and repeatedly that your suggestions can be, and often will be, rejected. Any sense of omnipotence you might naively have at the start of your training is rapidly lost, a fortunate outcome of those times when sessions just don't go the way you'd hoped.

COMMON MISCONCEPTIONS AND WHAT YOU MAY NEED TO KNOW TO COUNTER THEM

Presented in the remainder of this chapter are many of the most frequently encountered misconceptions about clinical hypnosis. You may be surprised how many people, including your colleagues and even self-described "hypnotists," believe some of these erroneous ideas.

Following each is a brief discussion providing ideas that can help you correct the misconception. As you become more familiar with hypnosis, and you find yourself talking more frequently about hypnosis to others, responding to these and other misconceptions will gradually become quite automatic for you.

Misconception: Hypnosis Is a Good Thing

In a very broad perspective, we can think of hypnotic experiences as a basis for the subjective realities we come to accept as our personal truths. This "reality" includes our worldviews, values, views on right and wrong behavior, and emotional makeup. You can appreciate how your quality of life is largely dictated by what you tell yourself about yourself and the world around you. How does it affect your mood, behavior, and physiology when you tell yourself, "Life is so unfair!" Likewise, how does it affect you when you tell yourself, "I can do this!" Each person has countless thoughts each day, ranging from profound to (mostly) mundane. Which ones you focus on, which ones you absorb as true, can generate symptoms ("I'm afraid to fly because what if the plane crashes?") or, conversely, can generate healthy choices ("I love the freedom to be able to go anywhere in the world I want to go!"). Suggestions, whether from oneself or another, can be used to help or harm. In that respect hypnosis isn't innately a good thing. It has the potential to be very good as a tool to help people when it is applied skillfully (Alladin, 2008; Lynn & Kirsch, 2006).

Misconception: Hypnosis Is Caused by the Power of the Hypnotist

In the clinical context, clinicians are able to use their skills in communication to make acceptance of suggestions more likely, but there is no control over the client other than the control the client gives them. The hypnotist directs the client's experience, but only to the degree that the client permits it. It is a relationship of mutual responsiveness (Gilligan, 1987; Zeig, 2001).

Misconception: Only Certain Kinds of People Can Be Hypnotized

One of the things that all hypnosis experts seem to agree on is that people differ in their hypnotic capacities, ranging from what are generally termed *low, medium, high*, and *very high* hypnotizables. Very high hypnotizables are sometimes referred to as *hypnotic virtuosos* (Hilgard, 1977). These are designations based on responses to formal tests of hypnotizability, which are described in Chapter 14. Clearly there are some people in whom it is more difficult to induce hypnosis than in others. What that means exactly is the subject of considerable debate within the field. Does it mean the person has some inherent limitation, such as a genetically or perhaps neurologically defined capacity for hypnosis or maybe that the test protocol used to assess hypnotizability somehow "misses the mark" for the person (Gfeller & Gorassini, 2010; Lynn & Shindler, 2002)?

The issue is a critically important one because if you conclude a person isn't hypnotizable due to some innate limitation, then there is no need for you to try performing hypnosis. If you believe those persons deemed low are not

significantly less capable than others but may be less responsive for any of a wide range of reasons, such as a fear of losing control, then you may strive to find and resolve the points inhibiting their responsiveness. Can difficult persons be transformed from poor hypnotic subjects into reasonably responsive ones? Many experienced clinicians and researchers would say yes (Gorassini, 2004; Lynn, 2004).

What Do the Hypnotizability Statistics Mean?

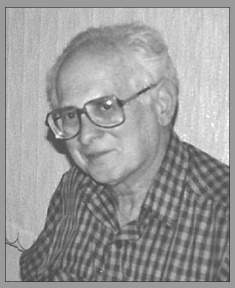
Formal testing instruments have been developed to assess the elusive quality called hypnotizability. In general populations, there is essentially a bell-shaped curve of hypnotic responsiveness, with the *low hypnotizables* at one end and the *very high hypnotizables* at the other. When a researcher or clinician states that any percentage of the population cannot be hypnotized using such standardized instruments, what should we conclude? Is the lack of response a personal limitation or a response to an impersonal approach?

Statistical averages for hypnotizability say too little about a given individual's capacity for experiencing hypnosis, and they predict too little about clinical outcomes. Furthermore, they are derived under circumstances that have little bearing on the therapeutic interaction. The figures are typically based on getting a sample of research subjects, running each of them through a standardized procedure as required by research, and then determining how many of them were able to demonstrate behavior thought to be associated with specific levels of hypnosis. The flaws in such studies are numerous.

First, the most serious fault of such hypnotizability studies is that standardized induction procedures do not recognize individual differences in subjects. Assessing individual differences and then specifically forming suggestions on the basis of those differences is the most fundamental prerequisite for successful clinical hypnosis, in my view. Using the same technique with each person without variation is one way of assuring failure with a significant number of people.

Experimental subjects who can respond to impersonal procedures are demonstrating considerable flexibility. Subjects who don't respond well to such standardized procedures may well be hypnotizable but may require greater individual consideration. In one-on-one psychotherapy with a competent clinician, such individuals would likely get that kind of individual consideration and thus be more likely to respond favorably. Furthermore, the motivations for research subjects are quite different from the motivations of therapy clients. Personal distress has a different effect on responsiveness than does intellectual curiosity, and a warm relationship with a clinician has a different effect than an impersonal relationship with a researcher (Perry & Sheehan, 1978; Sheehan, 1980).

Second, in studies of hypnotizability, the person's depth of hypnosis is measured by the demonstration of particular behaviors associated with presumed levels of hypnosis. For example, for a subject to demonstrate a hypnotic phenomenon such as age regression, the subject is assumed to be in at least



FRAME OF REFERENCE: ANDRÉ M. WEITZENHOFFER

One of the most knowledgeable researchers and clinicians to ever study and practice hypnosis was André M. Weitzenhoffer (1921–2005). With a strong "hard science" background in physics, engineering, and physiology and an insatiable appetite for understanding the nature of hypnosis, Dr. Weitzenhoffer gathered and integrated a broad array of hypnosis literature that eventually became his first book, a 1953 classic called *Hypnotism: An Objective Study in Suggestibility*. He received his PhD in psychology from the University of Michigan in 1956. After completing his book and degree, Dr. Weitzenhoffer was contacted by Dr. Ernest ("Jack") Hilgard, who initiated a collaborative attempt to establish a hypnosis research laboratory at Stanford University, which the two successfully did. (Dr. Hilgard is the subject of another Frame of Reference in Chapter 14.) Major effort was put forth by the two to develop a scale to measure hypnotic responsiveness, and the result was the Stanford Scales of Hypnotic Susceptibility, Forms A, B, and C. These scales are widely considered to provide the best "objective" measure of the elusive trait called *hypnotizability* and so continue to be a backbone of the research wing of the field of hypnosis. Dr. Weitzenhoffer eventually published over 100 scientific articles, books, and papers and also lectured nationally and internationally. He was a strong advocate of the need for scientific rigor in the study of hypnosis and was persuasive in arguing for continuing the search for what many researchers consider the "Holy Grail" of hypnosis, namely, the definitive proof that a state of hypnosis even exists.

Dr. Weitzenhoffer enjoyed his "retirement" by working almost as hard as ever, writing and teaching. In 2000, he published the second edition of his classic work, *The Practice of Hypnotism*, a critical and detailed consideration of many of the most important issues in the field as seen through Dr. Weitzenhoffer's wise eyes.

On the beginning of his interest in hypnosis: "I think, initially, it was a demonstration at a summer camp, done by a camp counselor, that kind of intrigued me. He did postural sway tests. He was a mesmerist, so he used passes. He would put people into a sort of hypnotic sleep, which was kind of weird. Later on, I went to a stage show and saw a magician that I don't think hypnotized anyone, but

everyone was convinced he was hypnotizing people. So, I began to look it up in the encyclopedia to find out more about it. I had an inquisitive mind for most of my childhood, and it sometimes got me into trouble, too. But, that's how my interest arose."[2]

On the start of the Stanford Hypnosis Research Laboratory: "Jack Hilgard came down just as I was doing the last six months of my dissertation. He told me at the time that he had read my book and that he was very impressed by the fact that there seemed to be a good scientific basis for hypnotism. He asked me if I would like to join him at Stanford and jointly start a laboratory. Before doing so, we both spent a year at the Center for Advanced Study in Behavioral Sciences, located in Palo Alto. Jack and I spent most of that time working on the details for the laboratory, what he and I had thought of doing, to see if we could work together.

"I think, at that time, about 10 years of research was mapped out.… But the first thing we both agreed was necessary was some kind of good instrument to measure suggestibility, to measure depth."[2]

On defining suggestibility and suggestions: "For me, suggestibility is the capacity to produce responses to suggestion. Okay, that's very broad, so, I also specify that the response must at least be non-voluntary.… If the nonvoluntary aspect is not there, you do not have a suggestion. By definition, suggestibility is the capacity to respond to a suggestion, that is, to produce a nonvoluntary response.… My definition of suggestion is that there must be something nonvoluntary I can establish as taking place or be satisfied it is nonvoluntary. The basic idea in the suggestion also must be fairly directly and clearly reflected by the behavior, either at the level of experience or at the level of actual behavior."[2]

On the idea of everyday hypnotic states: "For me, it is important to distinguish what is hypnosis—to define what it is and to define what it is not.… I don't like the idea of the everyday trance state because I don't think it has been clearly demonstrated that there are everyday trance states. If there are, I think the question obviously is: Are they a hypnotic state or not? … I'm willing to say that people go into altered states of awareness. There are all kinds of altered states of awareness, and I think that of all the altered states of awareness that exist, there is a certain class of these states that probably we can call trance states. I don't think all altered states of consciousness should be called 'trance,' however. Certain trances are hypnosis. Others are probably not. Likewise, I believe that hypnosis can probably be identified with a class (really a subclass) of trance states and that while one can probably say that hypnosis is a trance, one cannot say that all trances are hypnosis."[2]

On the quality of hypnosis in laboratory versus clinical contexts: "I reserve the word 'hypnosis' for the state or condition that has thus been named. I have no reasons for believing that it is fundamentally different when produced in the laboratory and produced in a clinical situation. However, it certainly can be experienced and outwardly manifests itself in different ways, and I cannot be certain

at this stage in my knowledge that these differences might not be associated with some fundamental (but not just qualitative) differences in the state itself. I know that some have said that laboratory and clinical 'hypnosis' were different, but I have always understood this to be a reference to the production and use of the state rather than the state itself."[1]

On lab findings directly relevant to clinical practice: "My main interest has been in checking out the reality and properties of hypnosis, of suggestions (and suggestibility) and of a few induced hypnotic effects. My work has provided a scientific foundation to the subject matter of hypnotic phenomena including the clinical uses of hypnosis. The three findings with the most relevance are: (1) the fact that, all other things being equal, all individuals do not respond equally well to direct suggestions; (2) the fact that under certain conditions, communications not intended to be suggestions will act as suggestions; and (3) the fact that direct suggestions give rise to automatisms (nonvoluntary and even nonconscious responses)."[1]

On assessing hypnotizability in clinical practice: "Unless a patient is taking part in a study that calls for such an assessment, doing one probably has no clinical value.* In clinical practice, I do not see that the scales are particularly useful unless you want to be rigorous. Because, for one thing, a good clinician, a good hypnotist, is going to very quickly get a good feeling for what the patient can do by just watching how the patient responds, whether he does it like Milton Erickson or he does it in a more traditional fashion. He gets some feedback which will tell him if the subject/patient is capable of developing specific responses under hypnosis.… The other thing is that they are an intrusion in the clinical situation. They are an element that seems to have nothing to do with therapy. Of course, you can tell the patient that, 'In order to help you, I've got to spend an hour testing you with this instrument.…' Anything else I'm going to find out would be in the course of working with the patient. If the patient can develop amnesia, I'll find that out presently. I start giving suggestions for it under the hypnotic state. Later, by asking questions I'll get some idea of how much amnesia is present. So that's why I say I don't see the use of the scales in the clinical setting as desirable."[2]

On the skills of good hypnotists: "The really skilled hypnotists have skills other than just giving a suggestion. They have skills in interpersonal relations, including the ability to empathize, establish rapport, and observe what the client is doing, keeping that in mind, integrating their responses into what is going on."[2]

On pleasant findings and disappointments: "My biggest pleasant finding (I would not say 'surprise') was finding evidence that suggested effects had a certain reality as elicited automatisms, that is, as nonvoluntary responses to communications. My biggest disappointment has been not being able to date to show beyond doubt that the state of hypnosis exists or does not exist."[1]

[1] *Personal communication, August 2002.*
[2] *Personal communication, December 1988.*

a medium level of hypnosis. Traditional concepts of hypnosis assume that if you can demonstrate phenomenon "X," then you must be at hypnosis level "Y."

This is an invalid assumption, for people demonstrate hypnotic phenomena continually in their everyday "waking" state (Capafons & Mendoza, 2010; Kihlstrom, 2008). For example, almost everyone has had the experience of being engrossed in a task and only upon its completion noticing an injury (e.g., cut, bruise) has occurred: "I'm bleeding! Now how did that happen?" Even when hypnosis has not been formally induced, alert and active people who are focused can still demonstrate various hypnotic phenomena.

Finally, formal studies of hypnotizability also make the assumption that you must employ formal hypnotic inductions for hypnosis to occur, which is not necessarily the case. People often enter spontaneous, informal experiences of hypnosis, and these transient episodes of absorption can be every bit as useful to a clinician who knows how to recognize and utilize them as are the formally induced hypnotic experiences.

What factors determine hypnotizability? The theorizing and debating in the field continue even now, just as it has for well over a century. The vital issue of hypnotizability will be addressed in greater detail later.

Misconception: Anyone Who Can Be Hypnotized Must Be Weak-Minded

This particular misconception refers to the all-powerful Svengali image of the hypnotist and is based on the belief that for a hypnotist to control someone, the individual must have little or no will of his or her own. Modern "scare stories," usually embedded within movies and television programs, about evil hypnotists who control people and force them into doing terrible things play on this misconception (Barrett, 2010a; Pintar, 2010b). As discussed earlier, the average person does not understand how hypnotized persons can be in control of themselves while demonstrating unusual behaviors at the direction of the hypnotist.

Each person has a capacity for will, but some people choose not to exercise their capacity to make choices, essentially giving the responsibility for themselves to others to manage. Such individuals passively assume a "victim" role relative to others, typically a reflection of their misperceptions about the futility of effort. The label of "weak-minded" is quite inappropriate for such persons (Nash, 2008a; Yapko, 2010).

To counteract any negative effect this particular misconception may have had on the hypnosis-seeking public, many clinicians have made claims to the effect that people with higher intelligence and stronger personalities will be better hypnotic subjects. The ability to be hypnotized is not reliably correlated with specific personality traits or other such factors as age or gender (Kihlstrom, 2008). Despite it not being fully true, some clinicians see a potential value in making the claim that intelligent people do better as hypnotic subjects

than their less intelligent counterparts. The potential value lies in the hope that clients view themselves as intelligent and thus are motivated to respond more readily. However, persons are seeking help at a time when their self-image may not be particularly good. If a clinician sets clients up to respond positively on the basis of intelligence or any other seemingly desirable personal characteristic and then they have a less than satisfactory experience with hypnosis, they may use the negative experience to validate their negative self-appraisal. This is only one example of how a well-meaning clinician can inadvertently do damage to a client. Rather than trying to get the person to identify with and become a model client, clinicians may better their skills in accepting what the client offers and using it as the basis for further hypnotic interaction.

Misconception: Once One Has Been Hypnotized, One Can No Longer Resist It

This misconception refers to the idea that hypnotists control the will of their subject and that once individuals "succumb to their power" they are forever at their mercy. As you now know, nothing is further from the truth, since the hypnotic process is an interaction based on mutual power, shared to attain some desirable therapeutic outcome. Even the most responsive clients can refuse to follow the suggestions of a clinician if they so choose.

One of the primary sources for this misconception is the stage hypnotist's use of "cues," specific words or gestures that the volunteer accepts as a trigger for entering hypnosis quickly. From the audience's perspective, hypnotists' use of a simple word or gesture to rapidly induce hypnosis is yet another dramatic demonstration of their power.

In clinical practice, it is often convenient to establish a cue to make subsequent inductions swifter and easier, but the power to induce hypnosis does not reside in the cue itself. Rather, it is the individual's willingness to respond that makes the cue a viable trigger for hypnosis. Should clients be given the cue but choose not to enter hypnosis, they will not. The cue, also called a "rapid induction signal," is effective only when clients choose to respond to it.

Misconception: One Can Be Hypnotized to Say or Do Something Against One's Will

This is among the most debated issues in the entire field of hypnosis. It raises many complex issues about notions of free will, personal responsibility for one's actions, boundaries in the therapeutic relationship, the potential for abuse of one's position, and other such issues related to professional and personal conduct. In the clinical context, the relationship between clinician and client is necessarily one of mutual responsibility and accountability. In theory, the clinician offers entirely benevolent suggestions that the client can freely choose to either accept or reject. In practice, however, this is far too simplistic

to be entirely true given what we have come to know about the phenomenon of *iatrogenesis*, meaning client symptoms either caused or aggravated by treatment. This can arise through the use of misinformed or inappropriate techniques, the exploitation of naïve or vulnerable clients, and the hazards of working with people who are sometimes psychologically quite disturbed. But these circumstances represent the exceptions and are atypical of therapeutic environments.

The capacity to influence people to do things against their will exists. There is little room for doubt that people can be manipulated negatively to do things seemingly inconsistent with their beliefs and attitudes (Bordens & Horowitz, 2002). To put it bluntly, undue influence and, at the extreme, brainwashing exist. In other words, controlling a person is possible under certain extreme conditions, but those conditions are not at all reflective of hypnosis applied in clinical contexts, where cooperation is emphasized rather than coercion. And they are far, far removed from the respectful and empowering approaches to clinical hypnosis promoted in this book. Further discussion of these issues is contained in Chapters 8 and 9.

Misconception: Being Hypnotized Can Be Hazardous to One's Health

There is some legitimate basis for concern about the use of hypnosis, but the concern should not be about the experience of hypnosis harming anyone. Instead, the concern should be about who practices hypnosis. Hypnosis itself is not harmful, but an incompetent clinician can do inadvertent damage, usually through ignorance, despite presumably having good intentions. This is true not only for hypnosis practitioners but also for any provider of health care.

The experience of hypnosis is typically both relaxing and absorbing. There is usually a slowing of physiological functions, such as breathing and heart rate, and typically the person's body is wonderfully comfortable. Such physical responses are healthy, effectively reducing stress and discomfort. Experience with hypnosis highlights the extraordinary amount of self-control one can attain, even of physical processes that are generally regarded as involuntary (Barabasz & Watkins, 2005; Rossi, 2000).

Misconception: Hypnosis Can't Harm Anyone

As alluded to already, it is not hypnosis itself that may cause someone emotional harm, but difficulties may arise due to misdiagnosis, the inappropriate content of a session, or the inability of a clinician to effectively guide the client (Barber, 1995; Lynn et al., 2010). The same conditions exist in any helping relationship where one person is in distress, vulnerable, and seeking relief. An inexperienced or uneducated helper may inadvertently (rarely is it intentional) misdiagnose a problem or its dynamics, offer poor advice, make grandiose promises, impose an antitherapeutic point of view, or simply waste the person's time and money (Frauman, Lynn, & Brentar, 1993; Kleinhauz & Eli, 1987).

Hypnosis often gives clients access to memories and feelings long outside of conscious awareness. These may be distressing, as they often are in therapy, and an inexperienced or poorly trained clinician may be unable or unqualified to handle such issues effectively. Another therapist with greater skill may have been able to use the exact same information or responses to therapeutic advantage. An unfortunate example is one self-proclaimed "hypnotist, healer, psychic counselor" I once encountered who described his use of hypnosis with a woman who presented the problem of feeling guilty about an abortion she'd had. He used hypnosis to have her vividly imagine the fetus was still alive within her. He then directed her to have a dialogue with it, even giving it a name, to explain why an abortion was necessary. He thought this would be a good technique for settling the matter and wondered why such a "reasonable" approach fared so badly. She left him feeling much worse than when she came in. His thoughtlessness confirmed her worst fears—that she had killed a person with a name and personality. Regardless of your views on abortion, you can probably recognize the inappropriateness of the intervention.

Clearly, hypnosis does not cause harm, but the ineffective or inappropriate use of hypnosis can. Ineffective use of any skill, whether it be surgery, psychological testing, or giving haircuts, can hurt someone. Just as dentistry is not dangerous but a poor dentist is, hypnosis is not dangerous but a poor hypnotist is. Theoretically, we have governmental agencies for regulating clinical licensure and practice, but, unfortunately, at the practical level, it is impossible to separate those who are competent from those who are not. To compound this problem, in most places people can and do practice hypnosis with little or no academic requirement or clinical training, much less licensure. A smart consumer will have to do some "shopping" for a competent, well-trained clinician who uses hypnosis.

The flip side of this delicate issue, and the best of all reasons for developing skills in hypnotic approaches, is the great emotional good that hypnosis can help generate. In its ability to teach skills and give people greater access to more of their own resources, hypnosis is a powerful means for enhancing emotional well-being.

Misconception: One Inevitably Becomes Dependent on the Hypnotist

Dependency is a need, a reliance on others, that everyone has to some degree. To a greater or lesser extent, we all depend on others for things we feel are important to our well-being. In the helping professions especially, people are seeking help at a time they are hurting and vulnerable. They depend on the clinician to care, offer comfort, and provide effective help.

Clinicians know that the ultimate goal of responsible treatment must be to help each client establish self-reliance and independence whenever possible. Rather than foster an unhealthy dependence by encouraging clients to view the clinician as the source of answers to all of life's woes, hypnosis used

properly helps persons in distress to discover, develop, and use their own strengths and resources. Consistent with the goal of self-reliance and the use of personal power to help oneself is the teaching of self-hypnosis to those you work with (Lynn, Matthews, Fraioli, Rhue, & Mellinger, 2006). Teaching self-hypnosis to your clients is a means for helping to ensure they can continue to work independently and grow in your absence. Furthermore, teaching them strategies for problem solving along with self-hypnosis can allow for the emergence of a self-correcting mechanism that can assure those you work with that they do have control over their lives. It gives you an assurance that you have done your work well.

Misconception: One Can Become "Stuck" in Hypnosis

Hypnosis necessarily involves focused attention, which may be either inwardly or outwardly directed. It is controlled by the clients, who can initiate or terminate the hypnosis session as they choose. It is literally impossible to become "stuck" in a state of concentration. Can you imagine getting "stuck" reading a book?

A source for this misconception is the infrequent occasion where a clinician has given suggestions to clients to end the hypnotic experience yet they remain in hypnosis. The inexperienced clinician may get anxious or even panic when clients do not respond to direct suggestions to open their eyes and return to the usual "waking" state. In such situations, clients are not "stuck" but rather simply choose not to terminate the hypnosis session for at least one of two reasons: Either they are quite comfortable where they are; or they are still working on completing the experience, that is, getting closure. The best thing to do in such a circumstance is offer an open-ended suggestion that clients can bring themselves out of hypnosis when they are ready to do so. In time, usually only a minute or two, they will complete the experience and open their eyes and reengage with you. Sometimes, a "check-in" and further suggestions for completion are necessary, as will be discussed later. Never, though, can someone not return, so this is one issue you need not lose any sleep over. Respect the choices of the persons in hypnosis. If they do not follow a particular suggestion, there is a reason for it, so don't press your demands; just "go with the flow."

Misconception: One Is Asleep or Unconscious When in Hypnosis

Hypnosis is not sleep. Observed from the outside, someone in hypnosis may physically resemble someone who is asleep, eyes closed and showing minimal activity. However, from a neuroscientific standpoint, these clients are focused, conscious, and alert (Barabasz & Barabasz, 2008).

A source of this misconception is the word *hypnosis* itself, a word derived from the Greek word *hypnos*, the word for sleep and the name of the Greek god of sleep (Gravitz, 1991). The word hypnosis was coined early in the 19th century

and has been used to describe hypnosis ever since. Many early theorists, most notably Hippolyte Bernheim in France in the late 19th century, thought of hypnosis as a special form of sleep, and this viewpoint was widely taught to students of hypnosis (Hull, 1933/2002). Thus, early practitioners reinforced this erroneous viewpoint each time they offered the ritualistic suggestions to "sleep deeply" or "wake up" to their clients. Hypnosis is not sleep, and even clients in deep hypnosis are oriented to external reality to some degree. Therefore, the use of obsolete phrases like *sleep deeply* is neither relevant to nor indicative of clients' actual experience and so should not be used in doing hypnosis.

Misconception: Hypnosis Necessarily Involves a Ritual of Induction

For as long as your attention is directed in an absorbing way, either inwardly on some subjective experience or outwardly on some external stimulus that, in turn, creates an internal experience and you are responsive to suggestions to alter your experience in some way, you can reasonably be said to be in hypnosis.

It should be apparent that the attentional qualities of hypnosis do not have to be formally induced through some ritual to occur. Likewise, the various hypnotic phenomena can and do arise spontaneously even when no induction has taken place. This is often a surprise to people who think of hypnosis as some "special state" that makes hypnotic responses possible. However, what decades of research has revealed is that whatever responses you can attain through hypnosis can also be obtained in other ways. You don't need the rituals of hypnosis; you need only the suggestions and the motivation of the client to follow them (Barber, 1969, 2000; Kirsch, 2011; Lynn & Green, 2011).

Misconception: Hypnosis Is Simply Relaxation

Conducting a relaxation session is not the same as conducting a hypnosis session. Hypnosis goes well beyond relaxation both in structure and intent. Relaxation feels good, but in doing hypnosis it is employed simply as a stepping-stone in the direction of facilitating more complex hypnotic experiences such as an age regression or anesthesia. No one would ever simply do a relaxation process and then expect the client to undergo a painless surgery without chemical anesthesia.

Must someone be relaxed, sitting with eyes closed for hypnosis to occur? No. Briefly mentioned earlier was the phenomenon called *alert hypnosis*, or what some call *waking hypnosis* (Bányai, Zseni, & Tury, 1993; Capafons & Mendoza, 2010; Wark, 1998). In these conditions, clients or research subjects are given suggestions to focus intensely on some activity, such as riding a stationary bike or running on a treadmill, and with their eyes open while physically active they are exposed to a hypnotic induction and then given suggestions to generate various hypnotic phenomena, which they may readily do (Bányai & Hilgard, 1978).

As you're learning, hypnosis can occur spontaneously while conversing, reading, and in countless other instances where one's attention is focused. You can be anxious, even in suspense, and still be wonderfully absorbed, as in "glued to a mystery." Thus, physical relaxation is not a necessary prerequisite for hypnosis to occur.

In clinical practice, however, relaxation is usually a part of the intervention, since it is soothing and reduces the stress often associated with people's problems. Relaxation generally makes it easier to enlist cooperation on the part of the client since most clients want or expect it as part of the therapeutic process. Relaxation also makes access to clients' resources easier. Furthermore, relaxation can highlight the subjective differences between the experience of hypnosis and the usual "waking" state, convincing clients that they have, in fact, experienced an altered state of consciousness that fits with expectations of what hypnosis "should" be like (Sarbin, 1997).

Misconception: Clinical Hypnosis Is a Specific School of Therapy

Is hypnosis a therapy in its own right? Hypnosis is quite unique as an approach. After all, how many other therapy approaches emphasize generating and using clients' dissociated and suggestible state for increasing therapeutic responses the way practitioners of hypnosis do? On the other hand, whatever resources you try to mobilize and whatever skills you try to teach clients may be better described in other specific models of psychotherapy. Thus, there is a legitimate basis for saying clinical hypnosis is not a specific school of therapy in its own right, like behavior therapy or analytic therapy, despite the popular use of the term *hypnotherapy*. Clinical hypnosis is a therapeutic tool that is not aligned with any one theoretical or practical orientation (Lynn & Kirsch, 2006).

So, what of the term hypnotherapy? Does it mean anything? It implies therapy delivered hypnotically, that is, through the creation and use of the subjective experience of hypnosis, to enhance treatment effects. And, as you have already learned, hypnosis can enhance treatment effects. There is something special about hypnosis that warrants giving it a unique position in the realm of treatment. But should it be considered a distinct form of therapy?

There are nearly as many approaches to the use of hypnosis as there are clinicians who use hypnosis, and inevitably they use it in a way that is consistent with the way they believe therapy should be conducted. So, for some clinicians, hypnosis is integrated with cognitive-behavioral approaches; for others it is integrated with psychodynamic approaches. For some, it is integrated with mind–body healing approaches, and for others it is integrated with preventive approaches. What one clinician who uses hypnosis does with it and what another does with it may be as different as night and day. Whatever belief system and style of therapy you currently practice will likely continue to be

meaningful to you as you discover ways to enhance what you already do by applying hypnotic approaches. Learning methods and principles of hypnosis is much like learning a language. You learn a common set of rules, words, and structures, yet you will still inevitably express yourself in your own unique way.

What About Hypnosis Scripts?

Many books and clinical trainings on hypnosis advocate the verbatim use of prepared scripts that have been written for all types of general problems, such as obesity, smoking, and phobias. This suggests that the script is the therapy: Reading these words to the hypnotized client will effect the cure. The use of scripts promotes the misconception that hypnosis in clinical practice can be standardized and that all clients can receive identical treatment as long as they have the same presenting complaint. Reading the same script to all smokers as if they are the same simply because they all share a bad habit is an obvious gross oversimplification. When such an approach fails, typically clients get blamed rather than the scripted approach.

The use of scripts robs hypnosis of its real potency, the strength derived from the recognition and use of individuals' unique experiences and needs. Spontaneity and flexibility are essential for best results in doing hypnosis. Even when a therapeutic strategy is worked out beforehand, as good treatment planning may require, a skilled clinician will still incorporate clients' spontaneous responses into the procedure. People will likely continue to use the term hypnotherapy to offer a label for what they do, but it implies the use of hypnosis and suggestion only in the most general sense, revealing very little else about what they actually say and do with their clients.

Misconception: Hypnosis May Be Used to Accurately Recall Everything That Has Happened to You

Clinicians need to understand how memory works to best utilize this most important aspect of the individual. Some have compared the mind to a computer in which every memory is presumed to be accurately stored and available for eventual retrieval under the right conditions. The computer metaphor is highly inaccurate, however, and has the potential to be hazardous if an unwary clinician operates on that premise (Mazzoni, Heap, & Scoboria, 2010; Wester & Hammond, 2011; Yapko, 1993a, 1994a, 1994b). The research on memory makes it abundantly clear that the mind does not take in experience and store it in exact form for accurate recall later. In fact, memories are stored on the basis of perceptions and so are subject to the same potential distortions. People can "remember" things in vivid detail that did not actually happen. Likewise, people can remember only selected fragments of an experience, or they can take bits and pieces of multiple memories and combine them into

one false memory. Memory, simply put, is not reliable; if you are looking for "truth," you are unlikely to find it in memory (Sheehan, 1995).

Can a memory be considered more reliable because it was obtained through hypnosis? Can hypnosis be used to uncover the truth of what actually happened in someone's past? The answer to these two critically important questions is no. The effects of hypnosis on memory will be explored in greater detail later. Suffice it to say here that hypnosis does not increase the probability of accurate recall and may even decrease it.

CLOSURE ON MISCONCEPTIONS

As you may have come to appreciate, hypnosis carries a considerable amount of "old baggage." However, it is a dynamic field undergoing ongoing development as serious-minded clinicians and researchers strive to better understand the components of effective intervention and the range of human capabilities. There is a lot of new and exciting research going on as you read this, and as new insights emerge about brain functions, mental processes, methods of therapy, and so much more, old myths will inevitably be replaced by scientific facts. Clinicians have to keep up with new research findings if they are to help quell the spread of misinformation.

FOR DISCUSSION

1. What is peer group pressure? How does it cause you to conform?
2. What personal qualities might allow you to resist peer group pressure? In general, are these positive or negative qualities?
3. How do your expectations influence your experiences? How is a "self-fulfilling prophecy" likely to be part of a stage hypnosis show?
4. How does a fear of losing control of one's self surface in everyday behavior? Offer some examples.
5. What fears did you or do you have about experiencing hypnosis? What apprehensions do you have about hypnotizing others?
6. When might a client's misconceptions about hypnosis be an asset to the clinician? A liability?
7. Why do treatment approaches become standardized? What are the advantages and disadvantages of standardization?
8. What is a "power struggle"? Why do they arise? Can they be prevented? If so, how?
9. What types of people do you think would be harder to hypnotize than others? Why do you think so?
10. How might clinicians inadvertently encourage dependency in their clients? What may be the underlying motivations?

THINGS TO DO

1. When appropriate, tell people you work or socialize with that you are studying hypnosis. What positive or negative reactions do you get? Are you surprised?
2. See a stage hypnosis show, if you have one in your area. How is hypnosis represented to the public? How might misconceptions be created? How does the hypnotist engender obedience? How are subjects recruited?
3. Ask acquaintances to describe their understandings about what hypnosis is and how it works. What common misconceptions are present in their descriptions?
4. Take peers on a "trust walk" in which you lead them around while they have their eyes closed. What feelings do they become aware of? What increases or decreases their willingness to follow you?
5. Interview hypnotists in your area and ask them what percentage and sorts of people cannot be hypnotized. What reasons do they give for their answer?
6. Find books that contain entire scripts for interventions and choose a script of particular interest to you to read closely. What sort of person would this script seem to be ideal for? Why? What sort of person would the script likely be terrible for? Why?

CHAPTER 3

CONCEPTUALIZING HYPNOSIS

How you think about the nature of clinical hypnosis profoundly influences your hypnotic style as well as the ways you will apply it. As we have seen, hypnosis is an ambiguous enough phenomenon to invite many different definitions and descriptions. Likewise, hypnosis invites many different theoretical perspectives regarding what makes it possible to perform hypnotic procedures and to elicit the often remarkable responses that people generate. As you would predict, these viewpoints often differ sharply and tend to raise more questions than they can answer. Thus, they stimulate meaningful research, lively debate, and ever deeper understandings of the nature of hypnosis.

This chapter provides an overview and discussion of some of the more influential theoretical perspectives of hypnosis informing today's clinicians and researchers. They are presented here in a highly abbreviated form as single, discrete theoretical perspectives to highlight the essential tenets of the model under consideration. However, there is a broad consensus in the field that no one theory fully explains all the facets of hypnosis. The complexities of the subject of hypnosis, and the even greater complexities of the human being capable of hypnosis, are so many that it seems highly improbable that a single theory will ever evolve to fully explain its origin and character. Thus, it is easy for most practitioners to appreciate the merits of each of these multiple perspectives and incorporate them flexibly into their practices. Just as most psychotherapists describe themselves as eclectic in their methods, practitioners of hypnosis also vary their conceptual and practical frameworks according to the demands of a given situation.

It can be helpful to think critically about each viewpoint, perhaps by first considering what it assumes and evaluating for yourself whether its assumptions seem reasonable and helpful to you. It may be especially helpful for you to consider each model of hypnosis first from the perspective of the clinician

operating within it, then the individual perspective of the client experiencing it, and finally in terms of the interaction of the two. This may help you distinguish between what may be intellectually interesting and what is clinically meaningful and effective.

The various models of hypnosis can be differentiated from one another in many different ways. It may be helpful, though, to characterize them in terms of whether they are generally intrapersonal or interpersonal in nature. *Intrapersonal* models emphasize the subjective traits and states of the individual hypnotized person as the basis for hypnosis. Intrapersonal perspectives focus only on individuals and what goes on within them. *Interpersonal* models emphasize the social or relational aspects of the hypnotic interaction as key factors influencing hypnotic experience. Interpersonal models focus on both members of the hypnotic interaction and what takes place between them that makes hypnotic responding possible.

CONTEMPORARY THEORETICAL PERSPECTIVES OF HYPNOSIS

The Neodissociation Model: Hypnosis as a Dissociated State

The neodissociation model of hypnosis developed by Ernest Hilgard (1974, 1977, 1991, 1992, 1994) continues to exert a profound influence on the field. As a highly respected researcher and pioneer in the in-depth study of individual differences in hypnotic responsiveness, Hilgard's views are well considered and, especially in light of recent neuroscientific evidence, have some significant empirical support for advancing the notion of multiple levels of mental functioning that can operate independently (Bargh, 2006; Uleman, 2005).

Hilgard's neodissociation model is based on the view that humans have multiple cognitive systems capable of functioning simultaneously. These are presumably arranged in a hierarchy under the control of an executive system, called an "executive ego" or a "central control structure." Cognitive subsystems may include habits, attitudes, prejudices, interests, and other latent abilities. The executive system is tasked with monitoring and formulating responses to ongoing subjective experience. In the condition of hypnosis, the various cognitive systems can function autonomously, effectively dissociated from one another to a significant degree. Hilgard described it this way:

> The central executive functions in hypnosis are typically thought to be divided between the hypnotist and the hypnotized person. The latter retains a considerable portion of the executive functions from his or her normal state—the ability to answer questions about his or her past and plans, as well as to accept or refuse invitations to move about or to participate in specific kinds of activities. At the same time the subject turns over some of his or her executive functions to the hypnotist, so that within the

> hypnotic contract, the subject will do what the hypnotist suggests, experience what the hypnotist suggests, and lose control of his or her movements if this is indicated. (Hilgard, 1992, p. 94)

The research sparked by the neodissociation model has been extraordinary in both volume and quality of findings and has led to some of the most important understandings within the field of hypnosis (Kihlstrom, 1985, 1997). Primarily though not exclusively an intrapersonal model, Hilgard's research, and that of other influential neodissociationists such as Kenneth Bowers (1990, 1992), has focused on the dissociative and other hypnotic capacities of individuals as the eventual determinants of successful hypnosis. Hilgard made a strong case for viewing hypnotizability as a measurable difference between and a stable trait across individuals (Hilgard, 1965, 1967).

Hypnosis as a Psychobiological Phenomenon

The newly emerging increasingly sophisticated scanning technologies for studying the brain and nervous system did not escape the notice of the hypnosis community. In the next chapter, I will detail some of the recent findings about the cognitive neuroscience of hypnosis. These findings generally support those theorists who have suggested hypnosis may be best understood as primarily a neurological or psychobiological phenomenon (Oakley & Halligan, 2010; Raz, 2005; Raz, Lamar, Buhle, Kane, & Peterson, 2007; Rossi, 2000; Spiegel, 2008).

Psychologist Ernest Rossi has been an especially prolific researcher and writer in the area of the mind–body relationship in hypnosis and the physiological correlates to hypnotic experience. Rossi (1982) proposed that hypnosis was a natural part of the body's regularly alternating cycles of attentiveness and relaxation called "ultradian rhythms" that occur every 90–120 minutes. More recently, continuing his research on hypnosis and physiology, Rossi (2003, 2009) has focused on the potential for neurogenesis as well as hypnotic influence at the genetic level.

Psychiatrists Herbert Spiegel and David Spiegel (1978/2004) hypothesized that hypnotic abilities are the product of the interrelationship of the brain hemispheres. Together they evolved what they call a "biological marker" assessment tool that takes the form of an eye-roll test (described in Chapter 14), which they believe reliably indicates an individual's hypnotic capacity (H. Spiegel, 2008). David Spiegel focused more recently on hypnosis as an attentional phenomenon, an intense and focused concentration that is also significantly mediated by neurological capacities and functions (D. Spiegel, 2008).

From his study of what he calls "broken brains," famed neuroscientist Michael Gazzaniga evolved what he called a "modular unit" model of the brain (1985). While not specific to hypnosis, it provides a neuroscientific basis for many of the key phenomena of hypnosis, particularly dissociation. Gazzaniga

described how different portions of the brain can function together but can also function autonomously. These separate but related sets of neurons, which he termed modular units, can have their own "triggers," creating experiences, or, more accurately, perceptions of experiences that are modifiable with input from other sources. For example, a person goes to a party, has a good time, and goes to bed feeling perfectly fine. He wakes up feeling depressed the next morning and naturally strives to understand why. The modular units for mood may have been activated by a dream, but since the person doesn't know that, he starts to hypothesize: "Maybe I was upset about that joke the others made about me that I thought I had just laughed off. But maybe I was really hurt by it and just didn't know it." Gazzaniga terms ours the "social brain" for its reliance on social cues for making meaning of our experience. It could reasonably be said that hypnosis is a condensed form of such interaction: accessing modular units of the brain with suggestions and organizing them in therapeutic configurations.

Hypnosis as a Passive or Permissive State

This theoretical perspective is rooted in the mid-19th century work of Hippolyte Bernheim, a famed neurologist associated with the University of Nancy medical school in France. He was the eventual cofounder with another well-known physician practicing hypnosis, Ambroise-August Liebault, of the so-called Nancy School of Hypnosis. Despite its origins nearly 150 years ago, Bernheim's views of hypnosis have remained influential: He famously said, "There is no hypnosis; there is only suggestion" (Bernheim, 1886/1957; Pintar, 2010a). Thus, many hypnosis pioneers such as William Kroger, MD, influenced by Bernheim's work, placed heavy emphasis on the power of suggestion as a means to influence the seemingly passive patient. In fact, Kroger once defined hypnosis as "the induction of conviction" (personal communication, December 21, 1989).

Is hypnosis a state of passivity? It's easy to see how someone might come to think so: the hypnotized client typically sits quietly, doesn't initiate any conversation or overtly behave in any proactive, goal-oriented way, and thus seems entirely passive and permissively reactive to the suggestions of the clinician. But, in this case, looks are deceiving. In exploring the actual subjective experience or phenomenology of clients in hypnosis, one discovers that they are anything but passive. They are typically quite active in attending to the suggestions, searching for their relevance, tailoring them to their needs, amplifying and diminishing aspects of the experience, and more. While clients may seem to be passive, they may, in fact, be anything but.

The commanding style of some clinicians also contributes to this theory's description of clients in hypnosis as passive or permissive because they are expected to fully respond to the suggestions of the clinician. No initiative on the clients' part is either expected or deemed necessary. Clients are essentially viewed as passive receptacles for the clinician's commands. Their only task is

to simply comply. If they fail to respond to the clinician's commands for some reason, they are typically deemed "resistant." The resistance is presumed to be evidence of some defense mechanism or pathology of some sort that needs to be identified and "worked through" before therapy can succeed. The possibility that clients simply find the suggestions unsuitable or the practitioner offensive is not well considered in this perspective.

If a clinician adopts a permissive style in guiding clients, a style that may be less direct and is certainly less demanding, clients are defined as active participants in the process of making suggested possibilities come to life. In such a client-activated approach, the "permissive state" theory of hypnosis is no longer as plausible.

Hypnosis as an Altered State of Consciousness (ASC)

The experience of hypnosis has been conceptualized by some as an altered state or even altered multiple states of consciousness featuring absorption and apparent shifts in subjective perceptions (Tart, 1969; Tellegen & Atkinson, 1974). In this primarily intrapersonal perspective, hypnosis is considered to be a unique and separate state of consciousness, relative to one's "normal" state of consciousness. The evidence for an ASC is in the contrasts between experiences before and during hypnosis. The hypnotic state, in this view, is created by the hypnotic induction process, which presumably alters the person's consciousness through the narrowing of attention to the offered suggestions. The ASC is thought to feature reduced defenses, greater emotional access and responsiveness, and greater access to unconscious processes (Barber, 1991; Nash, 1991).

The term *altered states of consciousness* is, like *hypnosis*, very imprecise. Consciousness is a subjective experience. What is *normal consciousness* relative to an altered state of consciousness? Aren't I altering your consciousness with each word, each page you read? WAIT! Think of a purple elephant with green ears! Did I just alter your consciousness? How much? Any time your awareness is shifted from one stimulus to another, your consciousness has been altered. The question, then, is this: if hypnosis is an altered state of consciousness, what is it altered from? Yet when hypnotized persons experience their body as numb, that is not a routine experience. Clearly, something has changed, but what and how it changed remain a mystery. The problem for many critics of the ASC perspective has been in the circular logic: responsiveness to hypnosis causes hypnosis, and hypnosis causes responsiveness to hypnosis; the ASC indicates the existence of hypnosis, and hypnosis indicates an ASC. Might there be an objective measure of hypnosis as an ASC? No specific physiological measure has yet been found to identify the hypnotic state. But does that mean there won't be one eventually?

Psychologist John Kihlstrom (2008) of the University of California at Berkeley responded to the altered state issue this way:

> Perhaps, though, the problem lies in the way that *altered state* is defined. If we believe that every state of consciousness is associated with some unique physiological signature … then the lack of a physiological indicator for hypnosis may be taken as evidence that hypnosis is not an altered state of consciousness after all.… But our present knowledge of mind-body relationships is simply not sufficient to make such correlates a necessary part of the definition. (p. 36)

The view of hypnosis as a distinctly altered state, or perhaps altered states, remains popular because of its recognition that people in hypnosis can experience things seemingly beyond their usual capacity. The idea of altered states of consciousness conveniently allows for that possibility and also for the variable proportion of people who can experience such states as described in susceptibility statistics.

Hypnosis as a Special Interactional Outcome

In older approaches to hypnosis, the induction was something a hypnotist "did to" a subject by employing formal scripts of suggestions. Using impersonal scripts suggests the power is in the incantation rather than in the quality of the relationship between clinician and client. The late psychiatrist Milton H. Erickson, MD, is widely credited with transforming the clinical practice of hypnosis from such ritualistic approaches to a more refined hypnosis defined in broader interactional terms (Haley, 1973; Zeig, 1980). His methods have collectively come to be called Ericksonian approaches, or, synonymously, utilization approaches (Erickson & Rossi, 1979; Rossi, 1980). Hypnosis, in this view, is a result of a focused and meaningful interaction between clinician and client. The current concept of "attunement" that some advocates of an interpersonal neurobiological perspective is a parallel idea (D. Siegel, 2010). The clinician, to be successful, must be responsive to the needs of the client and tailor his or her approach to those needs. The relationship is one of mutual interdependence, each following the other's lead while, paradoxically, at the same time leading.

The idea that the participants in the relationship are both leader and follower is a key point in this theoretical perspective. Clients' behaviors or feelings are fed back to them verbally or nonverbally, thereby creating a sense in them of being understood—the essence of rapport. Tied to verbalizations of what they are experiencing as true (e.g., "You're sitting there listening to me …") are respectful suggestions of what can become true (e.g., "… and you can begin to focus on a pleasant sensation"). Instead of imposing on clients the clinician's belief system of what they should do, the possibility is made available to them of something progressive they can do in their own way and at their own rate.

The important point in describing this theoretical perspective is that hypnosis is considered a natural outcome of a special type of relationship and

interaction where participants are highly mutually responsive. William Kroger, MD, an exceptionally skilled practitioner, reminded me to "always remember, the most important thing is to take the patient into your heart" (personal communication, December 21, 1989). The interactional view emphasizes respect for clients, offering possibilities but making no demands, which is ideal in therapeutic contexts. However, clearly these factors need not be present for hypnosis to occur. After all, stage show hypnotists have no special personal relationship to their subjects and are certainly not sensitive or responsive to their unique personal characteristics and personalities yet can still obtain hypnotic responses from them.

Hypnosis as a Sociocognitive Phenomenon

The sociocognitive persepctive (SCP) of hypnosis is a heavily weighted interpersonal viewpoint: It emphasizes the social nature of hypnosis and hypnotic phenomena that arise in response to suggestions. In fact, several variations of sociocognitive models described next each draw attention to different social forces operating in the hypnotic context. In general, the SCP discounts intrapersonal models such as the neodissociation model or any other view of hypnosis that suggests there is something special about hypnosis or that there is some special mechanism that accounts for it. Instead, the SCP asserts that hypnosis is a product of social behavior that is fundamentally the same in structure as other social behaviors.

The sociocognitive model emphasizes social factors underlying hypnotic responses but also focuses intently on the cognitive makeup of individuals, including their expectations, beliefs, attitudes, attributional style, and other such cognitive processes that influence social responsiveness (Lynn & Sherman, 2000).

Prominent sociocognitive theorists include Nicholas Spanos (1991; Spanos & Chaves, 1989), Irving Kirsch (1991, 2000, 2011), Graham Wagstaff (1986, 1991), and Steven Jay Lynn (Lynn & Green, 2011; Lynn, Kirsch, & Hallquist, 2008), all of whom have conducted significant research on the social and contextual forces affecting hypnosis as they interface with personal variables. As a result, sociocognitve models have exceptionally strong empirical support. Much of this research is summarized in a special issue of the *International Journal of Clinical and Experimental Hypnosis* on the topic of the SCP guest edited by Steven Jay Lynn and Joseph P. Green (July–September 2011).

T. X. Barber's "Hypnosis" Psychologist Theodore X. Barber was especially prolific in his writings and research into the multiple factors comprising hypnotic responsiveness. Barber was interested in characterizing hypnosis and hypnotic responding and believed that hypnosis was best studied as a social psychological phenomenon. He attacked the circular logic of hypnosis described in the previous section on altered state of consciousness and was

able to convincingly demonstrate that the impressive array of hypnotic phenomena people demonstrated in hypnosis could be generated just as efficiently when performing no induction of hypnosis at all, simply by asking motivated subjects to exercise their imaginations (Barber, 1969). Barber emphasized his point that a state of hypnosis was unnecessary to construct as an explanation for hypnotic behavior by putting the word hypnosis in parentheses.

Barber considered both intrapersonal characteristics of the client, such as fantasy proneness and imaginative ability, and interpersonal characteristics of the social context of hypnosis. He suggested there are four especially important behavior-determining factors regulating the hypnotic experience:

> (a) *social factors* that obligate the socialized subject to cooperate and try to actualize or realize the hypnotists's expectations and explicit suggestions; (b) *the hypnotist's* unique skills and personal characteristics (including creative ideas, communicative ability, and interpersonal efficacy) and the nature of the hypnotist-subject interpersonal relationship; (c) the effectiveness of the *induction procedure* in guiding the subject to think-with the suggestions; and (d) the depth of meaning, creativity, and "force" or "power" of the *suggested ideas*. (Barber, 2000, p. 208, italics in original)

Hypnosis and Social Role-Playing SCP theorists hold the perspective that hypnosis is nothing separate from normal experience and that the unusual behaviors associated with hypnosis can be accomplished by anyone sufficiently motivated to so behave in the absence of any mention of hypnosis (Kihlstrom, 1991, 2008; Lynn & Green, 2011). Hypnotic phenomena thus occur as a consequence of an interpersonal context labeled by the participants as "hypnosis." In their view, hypnosis exists only when someone is willing to play the socially prescribed role of a hypnotized individual. Theodore Sarbin, while at the University of California at Santa Cruz, and his colleague William Coe, of California State University at Fresno, are principal architects of the model characterizing hypnosis as a social role, elaborating the model in their book *Hypnosis: A Social Psychological Analysis of Influence Communication* (Sarbin & Coe, 1972). They described that the clinician and client play reciprocal roles in the hypnotic interaction. These roles are shaped by situational demand characteristics, including knowledge of what the expected or required behavior is, what the criteria of success are, and what rewards or punishments may be involved for specific behavior. Coe and Sarbin (1991, p. 305) identified six variables that influenced the quality of hypnotic role enactment:

> (1) role expectations of the subject, (2) the accuracy of the subject's locating of self in the miniature social structure, (3) motoric and imaginal skills, (4) role demands generated by specific features of the experimental or clinical situation, (5) the congruence of the hypnotic role with the subject's self-conceptions, and (6) the guiding and reinforcing properties of the subject's audience.

Sarbin's (1997) concept of role enactment as central to hypnosis led him to coin the phrase describing hypnosis as "believed-in imaginings." He described his view this way:

> Role conceptions have been fruitfully employed to describe social behavior of all kinds, not only hypnosis. Of central importance, both for social actions generally and for hypnosis particularly, is that the person is regarded as a doer, a performer, an agent, not an inert object that passively processes information. Instead of happenings in the mind, the focus of role theory is on what the person does and how he or she does it, taking into account immediate and remote contexts in which the performance occurs. (Sarbin, 1997, p. 204)

It should be emphasized that the role-playing model does not assert the notion that hypnosis is only role-playing. To the contrary, the roles may be evident, but the sum of the interaction is more than just the parts of the roles. People respond with automatic and proactive, spontaneous responses that transcend the demands of the role.

Thinking of hypnotic behavior as role-governed social behavior obviously defines this model as an interpersonal one, taking into account socially prescribed roles, expectations, power, and influence. Support for this perspective comes from a variety of research studies, addressing issues of whether hypnosis is mere compliance or whether responses are, in fact, nonvolitional. Classic studies conducted by psychiatrist Martin Orne, who was professor emeritus of psychiatry and psychology at the University of Pennsylvania, and Australian psychologist Peter W. Sheehan were among the very first to address the issues of the confounds of distinguishing simulating versus "genuinely" hypnotized subjects and the demand characteristics of hypnosis encounters that could yield responses that were merely compliant rather than hypnotic (Orne, 1959, 1962a, 1962b, 1966, 1971; Sheehan, 1973). An experimental scenario might involve a group of subjects who are instructed to behave "as if" they were hypnotized and mixed with a group of subjects who were overtly and willingly formally hypnotized. A number of "experts" in hypnosis are then challenged to discover which individuals were and were not "truly" hypnotized. Subjects who role-played hypnotic behavior were extremely convincing in their manifestations of hypnotic phenomena and were able to successfully confound the experts.

Role-playing has long been recognized by social scientists as a way of absorbing people's attention by encouraging them to "get lost in the role." Many therapeutic strategies such as psychodrama, behavioral rehearsals, role-playing exercises, and family therapy role reversals regularly involve role-playing as a way of rehearsing positive responses in troublesome situations or developing empathy for another person. Initially, clients typically feel self-conscious and uncomfortable in the role but gradually adapt to the role demands and are soon immersed in it. If you have never seen this kind of phenomenon,

perhaps you can use your own experience as an illustration. Can you recall a time when you were in a bad mood, perhaps even depressed, sitting around your house when the doorbell rang unexpectedly? After you wondered to yourself, "Who could that be?" you answered the door and there was a friend of yours just coming by for a casual visit. Charitably, you decided you didn't want to depress this person by being in a bad mood, so you began to act "as if" you were in a semidecent, or perhaps even good, mood. Did you notice that after a brief while you genuinely were in a good mood? Almost everyone has had this kind of experience, and it is a useful example to illustrate the power associated with playing a role.

Playing a role can even change people's behavior quite dramatically beyond the time they stop playing the role. This is a point long recognized, for even at the turn of the last century the philosopher and psychologist William James asked the question, "Does a person smile because he is happy, or is he happy because he smiles?" In some powerful research done by psychologist Philip Zimbardo at Stanford University, a mock prison was set up in the psychology building, and a group of student experimental subjects were divided into "guard" and "prisoner" roles. The results of the experiment were both startling and dramatic. A mentality associated with the role evolved, with guards becoming abusive and even brutal and prisoners becoming passive, obsessed with escape, and ultimately depressed and agitated. Role-playing behavior became so intense that the experiment had to be called off for everyone's well-being.

Role-playing as a theoretical perspective on the phenomenon of hypnosis is useful up to the point, wherever that may be, where the artificial experience becomes genuine, a "believed-in imagining" as Sarbin termed it. A client or research subject may begin by playing at hypnotic behavior, but at a certain, idiosyncratic point along the way a true hypnotic experience begins.

While the SCP model offers a great many insights into social forces influencing hypnotic responsiveness, the model's limitations in addressing the phenomenology of hypnosis as well as the neurobiological evidence for shifts in attention and processing are evident. In fact, as Christensen (2005) pointed out from her survey of members of the Society for Clinical and Experimental Hypnosis (SCEH), "the findings also support the conceptualization of hypnosis as primarily an 'identifiable state'" (p. 286). Thus, for many hypnosis experts, the phenomenon of hypnosis is at least as much intrapersonal as interpersonal.

The Reality-Testing View of Hypnosis

Can you estimate how far it is from where you are sitting to the nearest door? About how far apart are your hands from each other right now? What direction is that sound you hear now coming from?

These questions are answerable because you are able to use your visual, auditory, and tactile senses to gather information directly from the world

around you. Consciously, but much more so unconsciously, you are continually engaged in processing huge amounts of sensory input that floods your nervous system with bits of information that orient you. These tiny bits of information give you a sense of where your body is, what position it is in, and how near or far it is distanced from externals. This is referred to as a *generalized reality orientation* (Shor, 1959, 1970). You are probably not consciously aware of the sensation in your left shoulder until I draw your attention to it. Yet your shoulder (its nerves) is processing information, such as the gentle rub of your clothing against it or the room temperature, and that information is available to you consciously if you strive to notice it or nonconsciously if you don't.

Obtaining feedback from our senses about the world around us and striving to validate its accuracy is a process commonly called *reality testing*. Proponents of this primarily intrapersonal view claim that people are continually testing reality to preserve personal integrity and to alleviate the anxiety of uncertainty in not knowing our position in the world. This process is generally so unconscious we take it for granted. Psychologist Ronald Shor (1970), a pioneering contributor to hypnosis, described it this way:

> In all our waking life we carry around in the background of our awareness a kind of frame of reference or orientation to generalized reality which serves as a context or arena within which we interpret all of our ongoing conscious experiences. Under certain conditions—of which hypnosis is just one—this wide frame of reference or orientation to generalized reality can fade into the very distant background of our minds so that ongoing experiences are isolated from their usual context. When that happens, the distinction between imagination and reality no longer exists for us. (p. 91)

The reality-testing view of hypnosis theorizes that when individuals first enter and are then absorbed in hypnosis, their ongoing process of reality testing is affected, perhaps by an increased comfort with seemingly contradictory bits of information as Orne (1959) suggested when he described what he termed *trance logic*. Trance logic refers to the lack of need for experience to be rational or make sense. The hypnotized client can "freely mix perceptions derived from reality with those that stem from his own imagination" (Barabasz & Watkins, 2005, p. 67). Prominent Australian psychologists and hypnosis researchers Peter Sheehan and Kevin McConkey elaborated this point in some of their related research and concluded this was a key factor that distinguished "reals" from "simulators" in hypnosis (McConkey, 1991; Sheehan, 1992; Sheehan & McConkey, 1982).

When individuals suspend the process of obtaining feedback from the world around them by focusing inwardly as is characteristic of most, but not all, hypnotic experiences, they are minimally oriented to anything other than internal experience (Hilgard, 1977). The suspension of objective reality testing thus presumably frees the person to accept whatever reality is suggested.

The suggested reality, like any perceived reality, whether true or false, will determine the quantity and quality of behavioral and emotional responses. As Sheehan and McConkey (1982) showed, however, affirmed in later research by Lynn, Weekes, and Milano (1989), suspending or reducing reality testing to accept suggestions for perceptual shifts does not preclude reality awareness. People in hypnosis retain the ability to monitor and, if necessary, respond to situational realities and cues. Hilgard called this reality-based part of the person the "hidden observer."

Living in San Diego as I do, and as the majority of my clients do, I can do hypnotic processes such as one involving relaxing at the beach if I care to, since most people here are familiar with and enjoy that experience. The hypnotic suggestions might involve incorporating all the sights, smells, sounds, tastes, and tactile experiences associated with being at the beach into the process in such great detail that the client can genuinely feel as if he or she is "really" at the beach. If I ask the person, "Where are you right now?" he or she might well answer, "The beach." If I then ask, "No, really, where are you right now?" the person will almost surely say, "Your office." But, in doing hypnosis, the reality of being in my office several miles away from the beach is suspended long enough to accept suggestions related to the "realities" of being at the ocean.

If clients can let go of the need to have an objective reality immediately at hand, it increases the likelihood that they can accept suggested experiences. Having good focus and a good imagination obviously help, too.

The Conditioning Property of Words and Experiences

Three of the most advantageous properties of having evolved consciousness for us as a species are our abilities to reason, learn on multiple dimensions of experience, and communicate about experience (Brown, 1991). Evolution has allowed us to attach words to experience and thus represent experiences abstractly. Instead of our communication concretely being tied to a current need or experience, we can communicate about things that occurred millions of years ago or about things yet to come many centuries from now.

Dynamics of language and communication are discussed repeatedly throughout this book. When we seek to evolve a theoretical perspective for the various phenomena of hypnosis, recognizing the role of your words as triggers for complex, multidimensional, nonvolitional, focused, socially responsive, and contextually valid experience is absolutely crucial to the attainment of sophistication with performing hypnotic techniques. With this book, I aim to help you develop the knowledge and skills for being able to say something to your clients that will help them. Regardless of theoretical orientation, I know of no one who would suggest that what you say to the client is unimportant. How do mere words, those sequences of sound you produce, attain such power?

You are reading this book, specifically this page with lots of black ink marks all over it, in various configurations. The patterns of configuration form what you have come to recognize from years of learning and experience as words. As you read each word in a fixed left-to-right sequence, line by line, you inevitably take the words and attach them to your subjective experience of what they represent to you. The words on this page don't mean anything at all to you until you attach a meaning to them, and the meaning can come from nowhere other than your own experience of having learned what experiences the words represent. Without your attaching meaning to the words, the words on this page are meaningless. When you see the lines and squiggles of written words or hear the sounds of spoken words from a language that is unfamiliar to you, those markings and sounds are meaningless because you have no internal frame of reference for understanding them. Meaning is in you, not in the words. Since you use your own individual experience to attach meaning to a word, you can appreciate how the same word will inevitably mean different things to different people. The more abstract a word, meaning the more room for individual projection, the more this is true.

Exercises suggested throughout this book will help make this point clearer to you, but you have probably already had experiences in which your interpretation of a word or phrase differed from another person's interpretation sufficiently to make you wonder whether that person was from this planet. The differences in interpretation between people account for most communication problems in whatever context problems exist. My idea of what the "right" thing for you to do may be very different from your idea is of what the "right" thing to do is.

In the practice of clinical hypnosis, you will need to be sensitive to the words and phrases you use because of the idiosyncratic nature of your client's interpretation of them. The phrase that works well in helping you develop relaxation, for example, may sound like fingernails on a chalkboard to your client. The word that fits well for your understanding of a particular kind of experience may represent something entirely different to your client.

Words are conditioned stimuli representing internal experience (Watzlawick, 1978). Gestures are also conditioned stimuli arising from socialized experiences (e.g., head nods, hand gestures). Ultimately, though, people are unique individuals, communicating in their own way. Thus, flexible communication both expects and allows clients to interpret and respond in their own unique ways.

The model of hypnosis regarding the conditioning property of words and the experiences words represent is valuable for explaining many aspects of hypnosis. The process of attaching words to experience in linguistics is called *transderivational search* and has been a subject of considerable study in that field. It is, after all, how we make meaning of things said to us. It is how we establish the associations that have potential therapeutic benefit.

In hypnosis, the conditioning property of words and experience is apparent both in the process of the transderivational search clients undergo in attaching the clinician's words to experience and in the resulting physical, emotional, and sensory changes that occur while they are mentally absorbed. These changes, subtle but present, occur quite naturally all of the time but are accentuated in hypnosis. For example, when listening to someone describe the pleasure they had in eating at a good restaurant, why do you likely get hungry, salivate, and want to go to that restaurant at the first available opportunity? The experience of transderivational search involves you in attaching their words to experiences of pleasurable eating, and while your mind is absorbed to whatever degree it is you unconsciously react to the mental experience on motoric, sensory, cognitive, and affective levels. These automatic responses are collectively called the *ideodynamic* responses and were first elaborated by Bernheim in the late 19th century (Spanos & Chaves, 1991). The ideodynamic response refers to the conversion of an idea, a suggestion, into an actual dynamic response. The motoric, or physical, response is called an ideomotor response. Automatic thoughts are called ideocognitions, automatic sensory associations are called *ideosensory* responses, and automatic emotional associations are called *ideoaffective* responses.

Transderivational search and ideodynamic processes are deceptively simple but highly sophisticated characteristics of communication in general and clinical hypnosis in particular. The inevitable role of personal experience in attaching meaning to words accounts for a great deal of the individuality and uniqueness of each person's response to hypnosis. This primarily intrapersonal model does not, however, consider the relationship and situational dynamics that are inevitably a part of all hypnotic work.

CLOSURE ON PERSPECTIVES

Having been exposed to some of the most useful explanations for the phenomenon of hypnosis in this chapter, you may now have an appreciation for my earlier comments about the applicability of aspects of each and the inadequacy of any single one as a means for fully understanding hypnosis. As you continue to get more involved in the use of clinical hypnosis, you will undoubtedly discover the complexity and diversity of peoples' responses. These will necessitate you keeping an open mind about the specific elements of each model that seem most relevant to your interaction at any given time. The greater the flexibility you have in making use of the many models there are to work from, the better the response you will likely get to the work you do.

FOR DISCUSSION

1. How do your expectations affect your ability to observe objectively?
2. What is your reaction to the often used analogy between the human mind and a computer? Do you believe the mind is "programmed" and that a person needs to have "old tapes erased" when undergoing change? Why or why not?
3. What is "normal" consciousness? Do you experience altered states of consciousness? When? What defines it as an altered state?
4. How specifically do transderivational search and ideodynamic processes necessitate careful word choice in doing hypnosis?
5. What is "personal integrity"? As each class member gives a definition, what do you discover about the variety of experiences attached to an abstract term?

THINGS TO DO

1. Do a role-play in which you and your partner in turn both pretend to be deeply hypnotized. What do you experience?
2. Contact health-care providers in your area who identify themselves as "holistic" in approach. What do you discover about the variety of approaches called holistic?
3. Choose a role to play for a day. For example, if you are basically shy, play the role of someone very outgoing. If you are basically assertive, play the role of someone passive. Whatever role you choose to play for a day, really stay in the role, but first make sure it is a safe one to do. What do you discover about the role? How does it affect your perception of yourself?

CHAPTER 4

THE BRAIN IN HYPNOSIS

OVERVIEW

Brain research has proliferated during the last decade and continues to do so even now as newer technologies for examining neural processes continue to evolve. These allow us an unprecedented opportunity to study detailed aspects of brain functioning never before possible. To study the changes in a person's brain from microsecond to microsecond as he or she engages in some specific activity, such as listening to music or reading a book, measuring these changes in "real time," and determining where such changes may take place, is remarkable. These new sophisticated technologies for examining the workings of the brain hold the potential to answer many of the most basic questions about ourselves, such as what physically drives our thoughts, feelings, and behavior and what constitutes the physical basis for conscious experience and unconscious processes under various conditions.

Hypnosis in particular poses special challenges to our understandings of the brain. In hypnosis, there are cognitive, perceptual, physical, and behavioral changes that occur that generally manifest as a greater responsiveness to suggested experiences. It is a well-established fact that not everyone is equally responsive to hypnotic procedures, though. Researchers typically separate subjects into groups of *high, medium*, and *low* hypnotizables by formally testing their responsiveness to suggested experiences with standardized instrumentation (see Chapter 14 for details on this subject). By focusing on those who appear to have a greater hypnotic capacity, brain researchers attempt to address vital questions about the way the brain functions when in hypnosis

and also when responding to suggestions delivered during hypnosis. In this chapter, I describe some of the issues and recent findings associated with neuroscientific research of hypnosis. I also consider what they may imply for clinical practice.

WHY STUDY THE BRAIN IN HYPNOSIS?

The obvious answer to this preliminary question must nonetheless be stated directly: the brain is instrumental in generating the experience of hypnosis as well as the various hypnotic phenomena derived through hypnosis. As the principal organ of information processing, sensation, perception, volition, memory, imagination, and all the countless other mental processes it controls, understanding the brain holds the promise for providing us with information that is vital to better understanding ourselves as well as ways to improve the human condition.

What makes it possible for someone to focus intently on a quiet induction process in a noisy room, perhaps even reporting having no awareness for competing sounds? How is it possible that a suggested sensation of numbness can allow some focused individuals to undergo surgery without the use of any chemical anesthesia? As neuroscientists strive to understand the cascade of neurophysiological events that take place when one person invites another to "just relax and listen to my words," the research questions grow more complicated, and the research methods designed to answer such questions grow more sophisticated.

What are some of the questions researchers studying the brains of hypnotized individuals strive to answer? Here are just a few of the most basic questions brain researchers address:

- Are there morphological, that is, physical, differences between the brains of high and low hypnotizables?
- Are there cognitive differences between high and low hypnotizables that have a neuropsychophysiological basis?
- Are there physiological correlates of the hypnotic state that can be identified and measured?
- Are neurophysiologically measurable state changes a cause or reflection of the hypnotic experience?
- To what extent do the neurophysiological data reflect the hypnotic induction processes used rather than the hypnotic state itself?
- How does a suggestion get converted into a (cognitive, perceptual, behavioral, or physical) response?

Something changes during the experience of hypnosis: before the induction procedure, research subjects could focus on nothing but the pain in

their arm. Following the induction procedure and some direct suggestions for numbness (e.g., "your arm will feel completely and comfortably numb as all the sensation seems to drain out of it"), the pain is all but gone from subjects' awareness. *Something* has changed—but *what*? Has neuroscience fully answered this basic yet very complex question for us? Currently, the simple answer is no. The more complex answer is that brain research is challenging under *any* conditions but is further complicated by the ambiguous nature of hypnosis. Despite that, neuroscientists have begun to learn about activities in the brain of the person in hypnosis.

The first challenge is to answer the question of whether there is a distinction between "hypnosis" as a distinct state and the effects of suggestion. British neuroscientists David Oakley and Peter Halligan (2009, p. 264) made the following distinction that guides their work in the brain imaging of people in hypnosis:

> Operationally, "hypnosis" refers to a change in baseline mental activity after an induction procedure and typically experienced at the subjective level as an increase in absorption, focused attention, disattention to extraneous stimuli and a reduction in spontaneous thought. Hypnotic induction procedures comprise a set of verbal instructions that facilitate this particular mental state. Typical "hypnotic" phenomena, such as alterations in sensory experience and motor control, amnesia and the adoption of false beliefs about the self and the environment, require specific suggestions.… Also, the effect of hypnotic suggestion can be more evident at the level of brain activation.

The underlying premise in much of the brain research involving hypnosis has been that there is a specific measurable state called *hypnosis* even though it has not yet been identified and defined biologically. In fact, André Weitzenhoffer (2000), a leading proponent of the belief that there is a distinct hypnotic state yet to be discovered and measured, wrote, "The *only* argument with some weight that has been offered against accepting the reality of hypnosis is the impossibility thus far to find consistent and meaningful physiological correlates of the state" (p. 224, italics in original). He went on to ask, "But have we found physiological correlates of other mental activities whose reality is not questioned?" (p. 224). For Weitzenhoffer and many prominent neuroscientific researchers, there is a condition called hypnosis that must exist in an objectively provable way. (See the Frame of Reference with Weitzenhoffer in Chapter 2.) The assumption is that our current technologies, sophisticated as they might be, are simply not yet sufficiently advanced to fully achieve the task. That may well be true. It might also be true, however, that the qualities of attention and absorption that seem to characterize hypnosis are not different enough from other experiences to generate their own distinct biological signature.

The notion of a specific state of hypnosis that is neurologically distinct and measurable has been substantially revised in recent years as new

understandings about the brain in hypnosis have evolved. In general, the neuroscientific hypnosis research has moved in the direction of studying attention and attentional processes, since these are the integral components of hypnosis (Raz, 2005, 2011). Rather than there being a specific, unique location for the experience of hypnosis in the brain, the direction and intensity of attention and the types of mental activities encouraged will determine which areas of the brain are likely to be actively involved. As people in hypnosis focus their attention and respond to suggestions, sophisticated scanning technologies detect and measure changes in the brain that might offer insights as to what may be occurring there.

HOW IS THE BRAIN STUDIED?

There are numerous technologies currently available to neuropsychophysiological researchers to employ in their investigations of the brain in general and in hypnosis in particular. These include computerized electroencephalographic (EEG) frequency analysis, positron emission tomography (PET), regional cerebral blood flow (rCBF), single photon emission computed tomography (SPECT), magnetoencephalography (MEG), magnetic source imaging (MSI), functional diffusion tensor imaging (fDTI), and functional magnetic resonance imaging (fMRI) (Oakley & Halligan, 2010). Each of these has a different means of assessing brain functions. Each offers a specific type and quality of observation, thus yielding distinct though related findings.

A comprehensive review of the large body of neuropsychophysiological data regarding hypnosis is beyond the scope of this chapter. (For excellent reviews of such literature, see Barabasz & Barabasz, 2008; Crawford, 2001; Oakley & Halligan, 2010.) However, it would be valuable to describe the four primary brain imaging approaches to more knowledgeably consider some of the recent findings derived from them described later.

Electroencephalography

EEG is arguably the most well-established brain imaging technique. Electrical activity of the brain is recorded from electrodes placed on the scalp. The brain's relatively weak electrical signal is amplified and then decomposed into its frequency components. The traditional frequency bands studied are *theta* (4–8 Hz), *alpha* (8–13 Hz), *beta* (17–30 Hz), and *gamma* (30–60 Hz). Electrode locations are designated according to the corresponding brain areas (e.g., F = frontal, T = temporal, C = central, P = parietal, and O = occipital). Odd numbers refer to the left side of the brain, even numbers refer to the right side of the brain, and "z" is the designation for the midline (Ray, 1997). EEG research focuses on identifying which parts of the brain are most and least electrically active during some experience.

EEG and Event-Related Potentials

One of the relatively recent developments in EEG technology is the study of the EEG patterns of individuals while they are either listening to or watching some stimulus (called an exogenous or evoked potential) or are psychologically responding to some stimulus (called an endogenous potential). These stimuli are called events, and the brain's electrical changes (a series of peaks and troughs) in response to these events are called event-related potentials, or ERPs. To get an accurate read of an ERP, a stimulus must be presented many times; then the researcher averages the EEG time-locked to the stimulus presentation to reduce any random background brain activity to zero. By measuring the time it takes for an ERP to occur after the presentation of some stimulus and by taking multiple recordings from various areas of the brain (the more electrodes that are placed, the better to determine where activity is taking place), it becomes possible to determine the sequence and the timing of the areas in the brain activated by the stimulus.

An endogenous ERP that has been studied extensively relative to hypnosis is known as the P300, or, in EEG shorthand, a P3 wave. It is typically seen in response to either rare or meaningful stimuli and appears at about 300 milliseconds after the presentation of the stimulus. It may take longer, perhaps as long as 1,000 milliseconds (one second), depending on the complexity of the stimulus.

Positron Emission Tomography

First developed in the 1970s, PET measures the emission of positrons from the brain after the subject has either been injected with or inhaled a small amount of radioactive isotopes, called tracers. Obviously, it is an invasive technique. The tracers allow the activity of different parts of the brain to be measured by gauging the volume of blood flow to the region. As a region is activated, the amount of blood flowing to that region increases. By gauging the blood flow with the radioactive tracers, the result is a three-dimensional map with different colors representing different levels of brain activity.

Functional Magnetic Resonance Imaging

Oxygenated blood has different magnetic properties than deoxygenated blood (Oakley & Halligan, 2010). The fMRI technique is able to detect these differences and amplify them:

> The difference between the two can be taken as an indication of the intensity of metabolic activity in particular sets of neurons when blood flows through them. In fMRI, the participant's head is enclosed in a large external magnet that creates a strong magnetic field where the variations

> in blood flow are recorded. Because fMRI is less invasive than PET and offers better temporal and spatial resolution of brain activity, it has gradually become the method of choice for most cognitive brain neuroimaging studies. (Oakley & Halligan, 2010, pp. 82–83)

Raz (2011) suggested that as powerful as fMRI as a technique may be, it still has its limitations, not the least of which is because blood oxygenation levels don't represent or reveal consciousness or subjective experience. But fMRI has been regularly applied in hypnosis brain research. Most of the studies of the brain in hypnosis use these brain imaging methods for identifying changes in the subject's brain going from a resting state, often called the *default mode*, to the suggested condition (such as an analgesia or age regression). Thus, aspects of brain function that are important for learning, development, stress responses, and mind–body pathways may be better understood (D. Spiegel, 2008). In fact, suggestion has been shown to affect neural processing in a variety of areas, including reading (Raz, Fan, & Posner, 2005), pain (Horton, Crawford, Harrington, & Downs, 2004; Kong, Kaptchuk, Polich, Kirsch, & Gollub, 2007), and even suggested symptoms such as paralysis (Ward, Oakley, Frackowiak, & Halligan, 2003).

PAYING ATTENTION IN HYPNOSIS

Without the ability to pay attention, we would be overwhelmed by the vast amount of information available in sensory experience at any given moment in time. When people suffer disorders that affect their ability to focus, such as attention deficit disorder, physical pain, or severe anxiety, the resulting distress and impairments tend to be obvious. Clearly, the capacity to focus in a meaningful way varies across individuals. How do variations in attentional capacities influence a client's response to hypnotic interventions? Are these variations innate to the client, or are they accounted for by variations in procedures? Furthermore, will the therapist's expectations for and subsequent treatment of clients differ based on how their capacity to pay attention is viewed?

Beyond the individual differences evident as a result of physical and mental states, evidence described in the hypnosis literature suggests that attention and responsiveness will vary, even at a neurophysiological level, based on the type of suggestions offered (Barabasz, 2000; Barabasz, Barabasz, Jensen, Calvin, Trevison, & Warner, 1999; Oakley, 2008).

Selective attention refers to the ability to voluntarily focus on one portion of an experience while "tuning out" the rest. Focusing on a specific stimulus (e.g., words, gestures, silence, images, sounds, textures, memories) to the exclusion or near exclusion of other ongoing stimuli is the foundation upon which hypnotic experiences rest.

There are complex factors that determine what works its way into one's awareness, including the degree of sensory stimulation (how weak or strong

the stimulus is), the novelty of the stimulus, the person's response tendencies (arising from a complex interplay of socialization and genetics), the person's motivation to attend in the context under consideration, the person's mood, and the kinds and amounts of other sensory stimulation coexisting in the environment. This is why the cumulative effect of practice is so important; there will virtually always be multiple possibilities of things available to attend to at a given moment. In training oneself to be skilled in experiencing hypnosis or self-hypnosis, one is learning how to regulate one's attentional abilities.

Attention in the brain is correlated with activations in the anterior cingulate cortex and the frontal cortex. This is found to be true in hypnosis as well as in other cognitive tasks performed without hypnotic induction (Oakley & Halligan, 2009; Jamieson & Sheehan, 2004). The work of neuroscientists Helen Crawford, John Gruzelier, Vilfredo de Pascalis, and others shows a multistage process of frontal lobe shifts associated with hypnosis: the instruction to focus attention, typical of getting an induction process under way, features an engagement of frontal attentional processes. Upon suggesting relaxation, an inhibition of these frontal attentional processes develops. Once the person is in hypnosis, functional brain activity is redistributed depending on what suggestions the person is given (Crawford, 1994; de Pascalis, 1998; Gruzelier, 1998; White, Ciorciari, Carbis & Liley, 2009).

As neuroscientists focus on the nature of attention, they commonly describe different but related attentional subsystems in the brain (Raz, 2005). These different subsystems lend substantial support to the influence of dissociation in multiple-level responding. In fact, one of the premier pioneering hypnosis researchers, Ernest Hilgard, first described in modern terms the role of dissociation in hypnotic responding. (Hilgard was known for many key contributions to the field, including his codeveloping with André Weitzenhoffer the hypnotizability test that remains the gold standard in the field today, called the Stanford Hypnotic Susceptibility Scale; see Dr. Weitzenhoffer's Frame of Reference in Chapter 2.) Hilgard's formulation of the neodissociation theory of hypnosis, discussed in Chapter 3, has special relevance here (Hilgard, 1977). Hilgard postulated that an "executive system" served as the decider among conflicting inputs on different, lower levels of attentional processing (1977).

The current neuroscience supports this notion by identifying three attentional subsystems in the brain, the first of which is an executive attentional subsystem. Its function is defined as conflict monitoring. A second attentional subsystem is the *orienting* subsystem. Its function is to orient the individual spatially. If I say, "look *here*!", then I am directing your attention to a specific location (Posner & Peterson, 1990). A third attentional subsystem is known as the *alerting* subsystem. It orients the individual temporally. If I say, "Look at this *now*," I am orienting you in terms of both space and time (Posner, 2004; Raz, 2005; Simpkins & Simpkins, 2010).

The most salient point is that attention is not a singular mechanism. Rather, it is composed of multiple, interactive conscious and unconscious processes.

The implication is that different qualities of attention will be elicited by different qualities of suggestion. It is interesting, but hardly surprising, to discover from the neuroscience that different areas of the brain regulate the different types of attention. Thus, it is predictable that there are differences in brain activity across different types of hypnotic experiences.

In the same way that one's quality of attention regulates emotion, cognition, and motor activity, one's quality of attention will necessarily activate different regions of the brain depending on the content of one's focus. As cognitive neuroscientist John Kihlstrom (2003) observed, the neural correlates of hypnosis might well depend on what the person in hypnosis is focused on, absorbed in, or tasked with doing while in hypnosis. This may be one of the reasons why no single highly distinct neurological signature for hypnosis has yet been found.

Recent fMRI research at the University of Hull in England reported by Kirsch (2011) yielded data showing differences between high and low hypnotizables in the resting state in response to hypnotic induction. Rather than observing differences between lows and highs during cognitive tasks, the differences were observed when at rest between cognitive tasks. Further studies may reveal whether this represents some reliable marker of hypnosis.

HYPNOSIS AND REDUCING CONFLICT: DEAUTOMATIZING THE AUTOMATIC

When two or more stimuli are in conflict with each other, how does one decide which to attend to? This decision is the task of the executive system described already. Might hypnosis be used to filter out one of the conflicting inputs? Neuroscientist Amir Raz and his colleagues tested this possibility using fMRI and ERPs brain imaging techniques while subjects were hypnotized and exposed to the Stroop effect. Stephen Lankton, editor of the *American Journal of Clinical Hypnosis,* provided a succinct description of the Stroop effect:

> The Stroop effect is based on the work of John Ridley Stroop (Stroop, 1935). It involves having a subject report the color of letters that appear in words. The words are: "red" written in a font that is blue in color; "yellow" written in a font that is green in color; "green" written in a font that is red in color; and "blue" that is written in a font that is yellow in color, etc. When the subjects look at one of the words, they see both its *color* and its *meaning*. If those two pieces of evidence are in conflict, they have to make a choice. Because experience has taught them that word meaning is more important than ink color, interference occurs when they try to attend *only* to the ink color. The interference effect suggests a person is not always in control of attention. This is the Stroop effect. (Parsons-Fein, 2006, p. 129)

As Raz pointed out:

> It is an effect that takes place even if you do not want it to happen … Reading words is a deeply ingrained process. It is automatic for people who are proficient readers … Reporting the ink color instead of the color word that you are reading creates conflict and that translates into more errors on incongruent words. It also translates into slower reaction time or a decrease in speed. These two factors—more errors (or less accuracy) and slower reaction time—characterize Stroop interference. (Parsons-Fein, 2006, pp. 133–134)

Raz et al. (2005) were interested in how posthypnotic suggestions might affect visual processing in the Stroop conflict (effect). Subjects were divided into low and high hypnotizable groups based on standard assessment instruments and during hypnosis were given posthypnotic suggestions that when exposed to the Stroop test they would not see the stimulus words as meaningful words. Rather, they would "construe the input words as nonsense strings.… Posthypnotic suggestion caused highly hypnotizable subjects to view Stroop words as nonsense foreign signs" (Raz, 2005, p. 245). The net effect was to dramatically reduce Stroop interference in research subjects.

Raz explained the significance of this research:

> What my research findings suggest is that hypnosis can deautomatize certain processes for some people.… That says something about the ability of the brain, or higher brain functions, to override and exert top-down control over other brain regions that are probably responsible for the practiced event. And that may imply that we can take habitual behavior, or all kinds of behavioral patterns, and potentially modify them.… Words can translate into specific influences on focal brain regions, which is news—big news! (Parsons-Fein, 2006, pp.137–138)

The use of objective measures, specifically fMRI, ERPs, and behavioral measures, demonstrating the powerful effect of posthypnotic suggestions on an automatic process provides a neuroscientific basis for more carefully studying the effects of suggestion on other automatic behaviors (Egner, Jamieson, & Gruzelier, 2005). For clinicians in particular, who are obviously interested in deautomatizing bad habits and self-destructive behaviors in the clients they treat, hypnosis may have more value and measurable impact than previously realized.

MIRROR NEURONS AND HYPNOSIS

I make a distinction between *doing hypnosis* and *being hypnotic*. Doing hypnosis is relatively easy when compared with the complexity of being hypnotic. Being hypnotic means many things but especially conveys a sensitive

recognition of the power of words to heal and the power of relationships to inspire. The fact that these effects can now be demonstrated neuroscientifically is exciting.

Clinical hypnosis practitioners traditionally used the term *rapport* to describe the positive interrelationship between clinician and client. The evidence is unambiguous that rapport is correctly considered a vital ingredient in successful treatments. Later, the phrase humanistic psychologist Carl Rogers advocated, *unconditional positive regard* was widely used to describe the power of acceptance in the therapeutic relationship. Next, the term *therapeutic alliance* became the standard for describing the joining of clinician and client in the treatment process, again emphasizing the healing power that can come from such joining. Most recently, the term *attunement* has become popularized, largely based on the remarkable neuroscientific findings that indicate when we talk about *having chemistry* with someone, it is more than a metaphor; there really are mutual physiological changes that take place when people are attached and "in sync" with each other.

As an example, one study of physical measures of therapists conducting treatment showed that during moments of high positive emotion, both clients and therapists had strikingly similar physiological responses (Marci, Ham, Moran, & Orr, 2007). That is fascinating in and of itself. More fascinating, though, was the finding that clients later gave higher ratings of perceived therapist empathy at these times. The researchers wrote, "This research supports brain imaging data that shows humans are literally 'wired to connect' emotionally. There is now converging evidence that, during moments of empathic connection, humans reflect or mirror each other's emotions, and their physiologies move on the same wavelength" (p. 109).

The practice of clinical hypnosis involves a particularly intense quality of connection with the client. It would be fair to say that the hypnotic relationship is more intense, focused, and multidimensional than that found in many other approaches. The reasons are considered at many different points in this volume but may be summarized simply as an embodiment of the belief that the power of the relationship largely drives hypnotic responses.

Mirror Neurons, Attunement, Neurogenesis, and Neuroplasticity

Why do we react at a gut level—and at a neural level, too—to other people's actions or emotions? What did Marci et al. (2007) mean when they said, "Humans are literally 'wired to connect' emotionally?" They refer to a most telling discovery that first launched inquiry into how relationships affect our brains. As many important discoveries are, this one was made by accident in the early 1990s by a team of Italian researchers led by neuroscientist Giacomo Rizzolatti (Rizzolatti & Craighero, 2004). In an experiment, macaque monkeys' brains were "wired" to show which neurons were active while the monkeys engaged in different

activities. Specific neurons would "fire" when a monkey would grab an object, which was expected. But, fascinatingly, the same neurons would fire when the monkey was *passively watching* another monkey engaged in that same act of grabbing an object. Neurologically, it was as if the monkey's brain reacted in the same way whether he was doing it himself or just watching another monkey perform the action. The brain cells would mirror each other in different individuals. These brain cells came to be called, therefore, *mirror neurons*.

Humans also have mirror neurons. When we watch other people, a part of our brain actively registers what's going on, and portions also actively relate to their experience. Some experts in neuroscience have called our brains *social brains* for this very reason. (The implications of a social brain for the spread of depression was considered in depth in my 2009 book *Depression Is Contagious*.) Interestingly, brain scans of people who show serious social deficits, such as an inability to show empathy for others as in autism, show significant differences from the brains of people who can engage meaningfully with others.

The "chemistry" or "harmony" or "attunement" that takes place between people is a critical component of mental health. As psychiatrist Dan Siegel (2010, pp. 27–28) described:

> When we attune to others we allow our own internal state to shift, to come to resonate with the inner world of another. This resonance is at the heart of the important sense of "feeling felt" that emerges in close relationships. Children need attunement to feel secure and to develop well, and throughout our lives we need attunement to feel close and connected.

Can life experiences, including the experience of hypnosis, change the brain? Until relatively recently, it was believed that we are born with all the brain cells we will ever have. However, the discovery of neurogenesis—the creation of new neurons (brain cells)—changed our fundamental understandings of brain physiology. The ways life experience can help sculpt brain functions to some extent—a capacity of the brain to change itself through a process called neuroplasticity—is an extremely exciting area of current neuroscientific research (Doidge, 2007; D. Siegel, 2007, 2010). Hypnosis has been shown to promote both neurogenesis and neuroplasticity as a direct function of the attunement made possible, in part, by mirror neurons (Rossi, 2007; Simpkins & Simpkins, 2010).

Consider the implications: how important is the therapeutic relationship? By some estimates there are over 400 distinct forms of psychotherapy, and virtually all of them emphasize the necessity of a close alliance between therapist and client. Being hypnotic can change brains—and lives.

Psychologists Ernest Rossi and Kathryn Rossi have made a convincing case for describing the role of mirror neurons that have been activated in

hypnosis. They propose that current DNA microarray technology, which can measure changes in gene expression as a result of life experiences, and brain imaging techniques can show links between changes in consciousness, mirror neurons, the molecular-genomics (gene expression arising from environmental influences), and brain plasticity in therapeutic hypnosis (Rossi & Rossi, 2006). Their description of the relationship between suggestions and brain changes is detailed and highlights what other brain studies affirm:

> Neuroscience has documented the activity of "mirror neurons" in primates and humans that function as neural mechanisms for empathy whereby we understand others by observing their behavior and matching their brain activity patterns. Current research on mirror neurons and empathy is integrated with the history, theory, and practice of rapport and therapeutic suggestion in hypnosis. (Rossi & Rossi, 2006, p. 275)

The importance of carefully building the therapeutic alliance, the attunement, cannot be overstated. Some specific ways to do that are discussed later in this book. In their book *Neuro-Hypnosis: Using Self-Hypnosis to Activate the Brain for Change* (2010), psychologists C. Alexander Simpkins and Annellen Simpkins also emphasize the malleability evident in brain structures associated with focus and attention. Their book does an excellent job of bridging the gap between brain and mind and uses the growing body of evidence regarding brain plasticity to suggest ways to maximize brain function with hypnosis.

SOME SALIENT FINDINGS ABOUT HYPNOSIS FROM NEUROSCIENCE

EEG Studies

Some of the earliest brain research regarding hypnosis involved use of the EEG. For example, in the early days of hypnosis some eminent theorists and practitioners held the erroneous view that hypnosis was a special form of sleep. In fact, there are still hypnotists today who will instruct their clients to "sleep deeply" as a part of their induction process and "wake up" as a part of their realerting technique. They say these things despite their obvious incorrectness since hypnosis is not sleep. Such outmoded terminology is simply a carryover from the early days when the misconception of hypnosis as sleep was commonly held. (Related to the "hypnosis as sleep" perspective is the misconception that someone in hypnosis is unconscious and unaware of whatever is going on.) EEG research in the late 1940s (Gordon, 1949) and subsequent replications with ever-improving EEG equipment made it clear that the EEG

pattern of sleep was distinctly different from the wakeful and aware EEG patterns of hypnosis.

EEG frequency analysis today tends to focus on the issue of band frequencies associated with hypnosis, specifically the question of whether one band frequency, such as alpha or theta, is most representative of the hypnotized brain. Early studies in this area suggested that hypnosis is an *alpha state* (London, Hart, & Leibovitz, 1968; Nowlis & Rhead, 1968). This notion was widely popularized, even leading to "higher consciousness" workshops on learning to generate alpha rhythms and the creation of special "alpha wave synchronizing" machines made commercially available to help you do so. However, hypnosis is not simply an alpha state. The research on alpha waves as an indicator of hypnosis is quite ambiguous, but some research regarding alpha waves suggests they may indeed have some relationship to hypnotic susceptibility either before or during hypnosis (Williams & Gruzelier, 2001). Future research will be necessary to clarify this point.

Earlier EEG research has been criticized on a number of counts: inadequate establishment of hypnotic susceptibility profiles of research subjects, limited number of electrode placements on the scalp, and poor amplification and signal-processing capabilities of the equipment (Perlini & Spanos, 1991; Ray, 1997). Newer EEG research, however, is considerably more sophisticated because now multichannel recording technologies and more refined signal-processing capabilities are available that have obviated many of the previous problems. Such research focuses on EEG coherence, meaning the synchronization between different areas of cortex. High coherence between sites is interpreted as a stronger connection of shared functions and vice versa for low coherence. In one recent study, a group of high hypnotizables showed decreased coherence, and a group of low hypnotizables showed increased coherence (White et al., 2009). This is further evidence of the inhibition of frontal regions in hypnosis, as described earlier.

Studies of EEG brainwave activity tend to show that the theta band is associated with higher levels of hypnotic susceptibility both in eyes-open and eyes-closed prehypnosis baselines and also during the induction of hypnosis (Crawford, 1990, 2001; Graffin, Ray, & Lundy, 1995; Ray, 1997; Ray, Blai, Aikins, Coyle, & Bjick, 1998). Theta is also associated with focused attention (Schachter, 1977), clearly a necessary component of the hypnotic experience. Thus, as individuals enter hypnosis, EEG theta power tends to increase. This increase may be observed in low hypnotizables as well as highs but is more pronounced in highs (Crawford, 1990, 2001; Sabourin, Cutcomb, Crawford, & Pribram, 1990). However, research by Williams and Gruzelier (2001) suggests that increased theta is not a trait index of hypnotic susceptibility, though it may be one for simple relaxation. White et al. (2009) also did not find a significant change in theta. Thus, although theta seems likely to be positively associated with hypnosis, current research findings remain equivocal.

There is another EEG "marker" that is currently receiving a great deal of interest from researchers: the 40 hertz band. The 40 hertz band is a high-frequency, low-amplitude EEG rhythm that centers around 40 hertz that is associated with a condition of focused attentional arousal (Crawford, 2001). De Pascalis and Penna (1990) reported that high hypnotizables showed greater 40 hertz production in their right hemispheres during hypnosis, whereas low hypnotizables showed reduced activity in both brain hemispheres during hypnosis. DePascalis, Marucci, Penna, and Pessa (1987, 1989, 1998) also showed that high hypnotizables, compared with lows, both in waking and hypnosis conditions, have a greater capacity to access both positive and negative life-emotional experiences, a capacity associated to task-related hemispheric shifts of fast EEG activity in the 40 hertz band. It has been suggested that the 40 hertz band is the physiological marker of focused arousal (Sheer, 1989), which, presumably, further research will either affirm or deny.

What About EEG and Hemispheric Asymmetry: Is Hypnosis a Right-Brain Phenomenon? Believing that brain functions were separated according to brain hemisphere led to differing hypnotic approaches for each brain hemisphere, termed *hemihypnosis*. The history of this belief goes back to the 19th century (Raz, Schwartzman, & Guindi, 2008). The belief was popularized once again in the 1960s, this time from the wave of popular interest in *split-brain* patients who, because of severe and unremitting epileptic seizures, had the corpus callosum connecting their two brain hemispheres surgically severed (Gazzaniga, 1970; Sperry, 1968). The theory of a hemispheric asymmetry—*left brain–right brain* characterizations—was again proposed to explain hypnosis and hypnotic phenomena (Watzlawick, 1978). The theory suggested, despite no hypnosis-specific objective evidence to support it at the time, that hypnosis was a process involving "blocking the left hemisphere" while utilizing "right-hemispheric language patterns." Some went a step further and even declared the right hemisphere the "location" of the unconscious, an incorrect position in light of current data showing a distribution of brain functions—conscious and unconscious—in both hemispheres (Corballis, 2007; Crawford & Gruzelier, 1992; Raz et al., 2008).

Is there a hemispheric asymmetry in hypnosis? Neither hemisphere dominates as a reliable force in hypnosis, and either one can dominate depending on the specific task assigned to it. The same can be said to be true in non-hypnotic conditions. Highly hypnotizable individuals seem to show greater emotional arousal, faster emotional arousal, and greater EEG activity in the right parietal region (Crawford, Kapelis, & Harrison, 1995; Crawford, Clarke, & Kitner-Triolo, 1996; Gruzelier, 1998; Heller, 1993).

Psychologist Jean Holroyd (2003) of the University of California at Los Angeles (UCLA), in an excellent review of the mindfulness and hypnosis literature, described the similarities arising in recent EEG studies of both hypnosis and meditation. These have implications for the notion that brain functions

are either segregated or localized, that is, hypnosis is *here* and mindfulness is *there*. She wrote:

> The neurophysiology of deep hypnosis and deep meditation is similar.… Often there is cortical inhibition, as evidenced by very slow EEG theta waves.… High band theta is related to hypnotizability, and theta power often increases as people (both high and low hypnotizables) go into hypnosis.… EEG theta waves are also prominent in deep states of meditation.… The far frontal cortex and the anterior cingulate gyrus on the midline surface of the frontal lobe are areas where theta figures prominently in meditation studies.… In both the meditation and hypnosis investigations, areas where theta is prominent (frontal cortex and especially anterior cingulate cortex) are also perfused with blood, which means that they are working hard. (pp. 115–116)

Most important, though, are these statements:

> When meditation involves activities other than just concentration, EEG patterns change over the relevant cortical sites, depending on the meditation activity. In a direct parallel, when hypnosis involves suggestions, the appropriate sensory and motor areas of the brain may be activated even more than in the non-hypnotic condition. (Holroyd, 2003, p. 117)

The important phrase here is "depending on the meditation activity." It suggests that the distinctions between techniques with differing names that all share the common vehicle of manipulating attention are likely to be arbitrary. They show differing brain signatures not because they are different in character but because they differ in what suggestions the client is given.

Neurofeedback and EEG Entrainment The issue of frequency bands associated with hypnosis is a charged one as researchers hope and strive to identify the physiological markers of hypnosis. It has become charged in another way as well, as an applied newer technology involving brain waves draws the interest of both researchers and clinicians. Popularly known as *neurofeedback* but also as EEG biofeedback, the premise of neurofeedback is that much of psychopathology can be attributed to problems in brain timing, specifically the person's brain waves being "off" (disruptions in brain self-regulation called dysrhythmias). Self-regulatory deficits have been associated by proponents of neurofeedback to various symptom patterns, such as various arousal disorders (e.g., anxiety), attention disorders, mood disorders, seizure disorder, and specific learning deficits (Sterman, 1996). Neurofeedback involves brain exercises that are directed at teaching individuals to self-correct their brain wave patterns. The presumption is that if you correct the brain, the person's problems may correct as well. Research has shown that brain waves may be retrained on an operant conditioning basis, and some studies now suggest

that neurofeedback may be a viable treatment for disorders such as those mentioned earlier (Lubar, 1995; Sterman, 2000). Barabasz and Barabasz (1996) described the use of neurofeedback with alert hypnosis in the treatment of attention deficit hyperactivity disorder (ADHD). Research on EEG conditioning and possible associated neurobehavioral changes is ongoing, and given the relative newness of the technology future research will help determine its ultimate worth as a means of intervention.

Recently another strategy to manipulate brain wave patterns for the purpose of improving both hypnotizability and clinical symptom presentations has been investigated, called EEG entrainment. Unlike neurofeedback, which encourages self-regulation, EEG entrainment involves the use of a stimulus, called binaural-beat sound stimulation, to drive the brain. Binaural-beat sound stimulation is part of a brain wave changing process that may also include breathing exercises, guided relaxation, imagery processes, and binaural beats (Atwater, 1995).

A binaural beat takes place when two different sound waveforms are presented stereophonically through headphones to a subject who will have the subjective perception of a third "beat" frequency occurring due to the difference between the two sound waves. The effects of listening to the binaural beats may be subjectively experienced as relaxing or stimulating, depending on the frequencies used. In a study by Brady and Stevens (2000), binaural-beat sound stimulation was utilized to attempt to increase theta activity and, presumably, hypnotic responsiveness, in a small sample of six subjects, which it did in five of them. They also showed significant increases in hypnotic susceptibility in the low- and medium-susceptible groups but no change in the high. In a recent replication featuring a revision and enhancement of the earlier protocol and measurement tools, the researchers (Stevens et al., 2003) found no significant relationship between frontal theta power and hypnotizability. The theta binaural beat (TBB) entrainment did not influence hypnotic responsiveness.

Can hypnotic responsiveness really be increased by manipulating brain waves? It is tempting to think so, but it is far too early in such research to answer in the affirmative. The theory has gone well beyond the evidence.

Event-Related Potential Studies

ERPs have been studied extensively in relation to hypnosis for their potential as either markers distinguishing brain activity in low and high hypnotizables in waking and hypnosis conditions or at least as reflectors of underlying processes. ERPs are affected by information-processing strategies that arise in response to the type of task demanded of the person as well as the emotional aspect of a stimulus, such as surprise (Duncan-Johnson & Donchin, 1980). Thus, studying ERPs in studies of hypnotic alterations of perception and emotional states has been a fruitful avenue of research (Barabasz & Lonsdale, 1983; Crawford, Corby, & Kopell, 1996; De Pascalis, 1994).

FRAME OF REFERENCE: HELEN J. CRAWFORD

Helen Joan Crawford (1943–) is professor emerita at Virginia Polytechnic Institute and State University in Blacksburg. She worked in the Department of Psychology at the University of Wyoming from 1978 until 1987, when she began working at Virginia Tech.

Now retired, Dr. Crawford was one of the most highly visible and influential researchers in the field, having published dozens of scientific articles and book chapters on complex aspects of the neuropsychophysiology of hypnosis. Dr. Crawford received her doctoral degree in experimental psychology in 1974 from the University of California at Davis. From 1975 to 1978, Dr. Crawford was a research assistant in the Laboratory of Hypnosis Research in the Department of Psychology at Stanford University, under the leadership of Dr. Ernest Hilgard, a leading figure in hypnosis and the subject of a Frame of Reference section in Chapter 14. Dr. Crawford's work is known internationally, and she has been an invited visiting professor and scholar at some very prestigious institutions, including the Imperial College of Medicine in England, Aalborg University in Denmark, the University of Rome in Italy, and the Hungarian Academy of Sciences. Her scholarly work has earned her a number of awards, including the Bernard B. Raginsky Award for Leadership and Achievement from the Society for Clinical and Experimental Hypnosis for being a "Distinguished Teacher, Scientist, and Pioneer in the Field of Hypnosis," the Ernest R. Hilgard Award for Scientific Excellence from the International Society of Hypnosis, and the American Psychological Association Division 30 Award for Distinguished Contributions to Scientific and Professional Hypnosis. She served as president of Division 30 of the American Psychological Association from 1984 to 1985 and also served as president of the Society of Clinical and Experimental Hypnosis from 1989 to 1991. Dr. Crawford's enthusiasm for and commitment to her research is a contagious force when she describes what she does, despite her scientific modesty that sometimes lends itself to pleasant understatement.

On the biology of hypnosis: "There are physiological changes that accompany hypnosis. When a person is controlling pain, for example, there are shifts in frontal

lobe involvement that interact with other systems in the brain. It's not just the frontal lobe. With our fMRI, we see changes in the anterior cingulated cortex. It's all reflective of something that's differing. The person is cognitively processing, but in a different manner."[1]

On attention as the key: "It is quite apparent that there are individual differences in the abilities to focus or divide attention, sustain vigilance over time, or be diffuse in one's scanning of the environment. The relationship between individual differences in attentional abilities and hypnotizability, as well as shifts in attentional processing strategies during hypnosis, have been addressed in a number of studies using a diverse range of methodologies. Given that hypnosis involves often readjusting one's attentional and/or disattentional state, diffusely or selectively, it is not surprising that hypnotic susceptibility is a cognitive trait that correlates with sustained and focused attentional abilities" (Horton & Crawford, 2004, p. 136).

On whether hypnosis is a state or a trait: "There's a shift in cognitive processing in hypnosis. I think the use of the term 'state' is dangerously inaccurate. There's a shift in conscious awareness and that's as much as I can say about it. I'm not in either a 'state' or 'trait' camp."[1]

On using physical evidence of hypnosis to build client responsiveness: "Most people know very little other than what is in the media, and they have many misunderstandings about hypnosis. So, I tell them, 'It looks as if hypnosis is focused attention,' and then I make an analogy to what they do when they're focused. In the process, I'm giving them facts about where I want to go with them. I explain that when a person is hypnotized, even though they're very relaxed, it appears as if the brain is quite active. Therefore, they have control over themselves, and they can make decisions as to whether they want to participate or not. It really goes over very well.… They like the idea that they're getting more control."[1]

On distinguishing ability from attitude: "I make a distinction between ability and attitude. I'm not one of the advocates who says everybody is hypnotizable. There's a range of responsiveness in people, as measured by standardized scales. It's neurologically and genetically influenced. If someone is interested in knowing what a person's responsiveness is, tests can help. And they help the subjects themselves when they discover they have hypnotic ability."[1]

On going beyond biology into the social context of hypnosis: "The relationship with the subject or client is highly important. If a subject doesn't trust me, they won't be hypnotized. You have to develop rapport ahead of time. When I walk into a classroom or a setting where hypnosis is involved, I'll talk to them for 10 or 15 minutes before I ever start the experimental hypnosis session. I'll tell them about hypnosis, address their beliefs and any misunderstandings, and I usually tell them about working in the area of pain control, which I publish on. It gives them a feeling that, 'Oh, this is possible.' It's good for developing rapport and building expectancy."[1]

On why psychotherapists should know about brain physiology: "I think the more you know about brain physiology the better you are in recognizing whether your patient's problems are psychological or whether there might be some underlying neurological problem. I respect therapists a lot, but too often they just don't understand clinical neurophysiology, and they miss physical reasons for their patient's problems. They need to be able to address the physical as well as the psychological."

Updated May 18, 2011, with the assistance of Julienne Crawford

[1] *Source: Personal communication, June 17, 2002.*

Two recent studies in particular (Barabasz et al., 1999; Jensen, Barabasz, Barabasz, & Warner, 2001) were quite persuasive in showing that when subjects were carefully chosen and grouped for hypnotizability and when suggestions were carefully worded, the ERPs showed significant differences between groups, supporting the notion of identifiable alterations in consciousness in hypnosis.

More specific are the somatosensory event-related potentials (SEPs), which have been studied in relation to human pain responses. As Crawford (2001) reported, hypnotically suggested analgesia results in significant decreases in the later SEP components (100 msec or later after stimulus) in hypnotically responsive patients. This suggests an inhibitory process that affects the anterior cingulated cortex, a portion of the brain known to show increased activation during pain.

POSITRON EMISSION TOMOGRAPHY STUDIES AND HYPNOSIS

A number of studies of hypnotic phenomena have been done using PET scan technology. In one study, Szechtman and his colleagues (Szechtman, Woody, Bowers, & Nahmias, 1998) at McMaster University in Ontario, Canada, used PET to image the brain activity of high hypnotizables prescreened for their ability to hallucinate in hypnosis who were given suggestions for an auditory hallucination. While in the PET scanner with their eyes covered, the subjects brain activity was monitored under four conditions: (1) at rest; (2) while presented a recorded stimulus of a voice saying, "The man did not speak often, but when he did, it was worth hearing what he had to say"; (3) while simply imagining the voice on the recording; and (4) while hallucinating the voice after being told the recording was playing when, in fact, it was not.

The PET scans showed that a region of the brain called the right anterior cingulated cortex was equally active when the subjects were hallucinating as

when hearing the actual recorded voice. But that same part of the brain was not active when the subjects were simply imagining the voice on the recording. Remarkably, the brains of these subjects had registered the hallucinated voice as if it were real.

In another PET study of hypnosis, this one conducted by Pierre Rainville and his colleagues at the University of Montreal (Rainville, Duncan, Price, Carrier, & Bushnell, 1997), the goal was to learn something about the brain structures associated with relief from pain during hypnosis. PET scans were done on hypnotized volunteers whose hands were immersed in painfully hot water. The somatosensory cortex, which processes painful stimuli, showed no significant differences when suggestions were given that either the water would be painfully hot or would be minimally unpleasant. But the anterior cingulated cortex, a part of the brain known to be more active in individuals in pain, showed much less activity when suggestions were given that the water would be minimally unpleasant.

A third study using PET scan technology, one that received considerable media attention, was conducted at Harvard University by Stephen Kosslyn and his associates (including David Spiegel, who is featured in a Frame of Reference in Chapter 20; Kosslyn, Thompson, Constantini-Ferrando, Alpert, & Spiegel, 2000). The study was designed to find out whether hypnosis could be used to modulate color perception. Research subjects chosen for their high hypnotizability were shown a series of patterns some involving colors and some only shades of gray while in waking and hypnotized conditions. Color stimuli were shown to be processed in a separate region from the gray stimuli. Researchers suggested that the subjects visualize each image shown them as either color or black and white while the PET scan measured brain activity. When subjects were hypnotized, the color areas of the brain were less active when told to see color as only gray, and, likewise, the color areas were more active when told to see (i.e., hallucinate) the gray stimulus as colorful. The brain areas used to perceive color were activated in both brain hemispheres, despite exposure only to shades of gray, just as they would activate when genuinely exposed to color stimulus. When subjects were not in hypnosis, and were told to simply visualize the colors, only the right hemisphere became active. Thus, the brains of hypnotized individuals responded to the suggested experiences rather than the actual stimuli in measurable ways. The researchers concluded that hypnosis is a psychological state with distinct neural correlates.

OTHER NEUROPSYCHOPHYSIOLOGICAL RESEARCH FINDINGS

Hypnosis clearly involves attentional processes, specifically selective focusing. Neuropsychological studies have suggested that the frontal lobe is associated

with attentional functions (Stuss, Eskes, & Foster, 1994). During hypnotic analgesia, Crawford, Gur, Skolnick, Gur, & Benson (1993) showed an increased cerebral blood flow in the orbitofrontal cortex, which may be interpreted as a sign of greater attentional effort on the part of subjects. In fact, Gruzelier (1988, 1990) and Crawford and Gruzelier (1992) theorized that differences in hypnotizability are, at least in part, due to varying capacities for attention across individuals, measurable with frontal lobe activation. Some behavioral research suggests that high hypnotizables have greater ability to focus and to sustain their focus (Roche & McConkey, 1990). However, Kallio, Revonsuo, Hamalainen, Markela, and Gruzelier (2001) did not find any evidence of frontal differences between high and low hypnotizables.

The ability of hypnotized persons to focus and respond nonvolitionally has often been deemed an effortless process (Bowers, 1992; Ruehle & Zamansky, 1997; Weitzenhoffer, 2000). Indeed, in the majority of hypnotic interactions, clients appear to be sitting passively and merely absorbing noncritically the suggestions of the clinician (or researcher). However, despite the appearance of effortless passivity, they are active, participating in the process, and searching for the relevance or salience of suggestions, particularly when they hold the potential to help with solving personally distressing problems. These observations about the active experience of clients in hypnosis have been lent substantial support in recent EEG and cerebral blood flow studies (Crawford, 1994; Crawford & Gruzelier, 1992) as well as psychological research (Kirsch, Burgess, & Braffman, 1999), which show that hypnosis involves substantial cognitive effort.

Problem solving, whether in the course of daily life or specifically in the context of attempting to resolve troublesome physical or psychological symptoms, requires some degree of cognitive flexibility. Cognitive flexibility implies an ability to view a situation from a variety of perspectives rather than only one (Beck, Rush, Shaw, & Emery, 1979), an ability to refocus attention and shift cognitive strategies, and other abilities such as vivid imagination and holistic thinking (Crawford & Gruzelier, 1992). Cognitive differences between high and low hypnotizables have been documented in a variety of studies (Spiegel & Spiegel, 1978/2004; Wallace, 1990; Weitzenhoffer, 2000). High hypnotizables tend to have greater cognitive flexibility, more focused attention involving the frontal attentional system, and greater capacity for emotional arousal (Crawford, 1989).

NEUROPSYCHOPHYSIOLOGY IS A YOUNG FIELD

The technologies for being able to peer into the brain as it functions are relatively new ones, and each new technological innovation holds the promise to reveal ever more about how our brains function in various conditions. The fact that brain research involving hypnosis has sometimes shown contradictory

findings should not come as a surprise to anyone. Similar contradictory findings are to be found in even less objective psychological research. Why is this so? There are many reasons:

- The experience of hypnosis represents a subjective state that, at best, researchers try to define and quantify in some way. But subjective states cannot easily be defined or quantified. If I say, "I love chocolate," and then I say, "I love my wife," will we find neurological correlates to these seemingly differing subjective experiences of love?
- Subjective states cannot usually be measured directly. They must be inferred from some agreed upon markers. How valid are the neurological inferences in representing actual phenomenological experience?
- When there is a negative finding—that is, nothing measurable happens in a hypnotic experience or in response to a hypnotic suggestion—does that mean the hypnosis procedure was actually ineffective? Or that the experience of hypnosis wasn't attained by the research subject (or client)?
- The research currently focuses on those deemed high hypnotizable as a sensible place to look for the markers of the hypnotic experience. The research on low and medium hypnotizables is less well developed, and it is still a subject of considerable debate as to the actual differences between lows and highs in terms of brain functions.
- The studies vary substantially not only in the way they define hypnotizability (or is it susceptibility?) but also as to which specific test instruments they employ to differentiate highs from lows.
- The technology used to assess changes in brain functions in response to hypnosis can only measure what they can measure. As Dr. Graham Jamieson of the Department of Cognitive Neuroscience and Behavior of the Imperial College Faculty of Medicine commented to the members of a scientific hypnosis computer listserv (June 12, 2002), "… perhaps it is time to move beyond course [*sic*] grained concepts such as 'focused attention' to consider the internally fine grained models now emerging in the cognitive-neurosciences. These models emphasize the rapid reciprocal flow of information between functionally and anatomically distinct subsystems. Traditional measures such as averaging (ERPs) and (frequency) bandpower are poorly suited to tap these relationships."
- The studies vary substantially in the way the researchers word the suggestions they offer their research subjects.

The brain research on hypnosis is an invaluable source of information about hypnosis and hypnotic phenomena. Such sophisticated research represents the crossroad where subjective perceptions intersect with their neuropsychophysiological correlates. Future research involving ever more advanced

neuroimaging strategies and devices are already on the horizon. Researchers are beginning to employ combinations of existing devices (e.g., fMRI, or PET, or SPECT neuroimaging in combination with EEG or magnetoencephalography, known as MEG) and newer technologies such as diffuse optical tomography (DOT), a noninvasive optical-imaging process involving near-infrared light applied to tissue surface providing an absorption spectrum for the tissue (see Diamond, Howe, Boas, Stanley, & Denner, 2002).

WHAT DOES BRAIN RESEARCH MEAN TO CLINICIANS USING HYPNOSIS?

First and foremost, EEG, MEG, PET, SPECT, fMRI, and other scanning technologies offer an unprecedented opportunity to probe the workings of the brain. Involving hypnosis in the process as a research variable can be a valuable means of studying cognitive phenomena that can yield insights affecting the course of treatment (Raz & Shapiro, 2002).

Despite the gains to be made from brain research, however, there are several issues complicating the treatment process that clinicians should consider, including the following. Can we—*should* we—attempt to define peoples' experiences, especially their problems, in solely biological terms? As advocates of neurofeedback suggest, should we define depression, anxiety, and numerous other disorders merely as brain wave dysrhythmias? Similarly, the drug industry has strived to define such disorders as evidence of a neurochemical imbalance requiring medications. However, the evidence is overwhelming that almost every disorder has psychological and social correlates, as well as physical ones. Depression, for example, is about much more than just "bad chemistry" (Yapko, 2001b, 2009). Likewise, the experience of hypnosis takes place in a physical context, a social (interpersonal) context, and it involves personal characteristics such as motivation to attend and expectations. Hypnosis is much more than brainwaves, cerebral blood flow, and hemispheric activation. Despite this point, clinicians should be aware that brain physiology matters and that what could be interpreted as psychologically based symptoms may well have biological underpinnings. Medical and even neuropsychological evaluations are generally a sensible first step in treatment.

Does experience alter brain chemistry and even brains themselves? Neuroplasticity refers to the changes in the brain as a result of experience. In fascinating descriptions of examples of neuroplasticity in his 2007 book *The Brain That Changes Itself*, neuroscientist Norman Doidge described mechanisms and consequences of neuroplasticity. The use of experiential processes such as hypnosis appear to encourage neurogenesis and neuroplasticity (Halsband, Mueller, Hinterberger, & Strickner, 2009; Simpkins & Simpkins, 2010; Yapko, 2011b).

Studies of brain changes as a result of psychotherapy reinforce the growing awareness for the phenomenon of neuroplasticity. In one study (Brody et al., 2001) at UCLA, comparing brain changes in a 12-week trial of antidepressants to interpersonal psychotherapy, the magnitude of brain changes were highly similar. In another study (Martin, Martin, Rai, Richardson, & Royall, 2001) conducted in England, interpersonal therapy compared with the antidepressant Effexor (venlafaxine) yielded similar results. These studies showed that in response to psychotherapy alone patients demonstrated decreases in prefrontal cortex activity, increased activity of the cingulated gyrus, and increased activity of the caudate nucleus. Such studies naturally raise more questions than they answer. But every clinician must consider that in the multiple entry points into the subjective world of the client, each interaction has an effect, as well as potential effects, on multiple levels, including neurological ones.

When is hypnosis a treatment tool of choice for someone? Dr. Crawford weighed in on this issue when she recommended using hypnosis early on in the treatment of pain, a domain where the biological evidence for a hypnotic effect is substantial (Crawford et al., 1998) before the patient develops strong pain memories and before surgery and long courses of drug treatment are initiated. One might offer similar criteria for someone suffering distress of any sort: helping the person by using hypnosis before acute distress becomes chronic, and when appropriate, of course, before techniques other than self-regulation approaches are employed.

Does hypnotizability testing to distinguish between high and low hypnotizables bias the clinician's treatment or inform it? There are good arguments for either viewpoint, and these will be explored later. Suffice it to say here that wanting to assess and enhance someone's cognitive and behavioral flexibility is of primary importance in doing treatment, given the implicit and often explicit messages to the client: "Look at your circumstances differently" and "Do something different."

Hopefully, you have now begun to develop an appreciation for the complexities associated with striving to understand hypnosis and hypnotic phenomena on a neuropsychophysiological basis. There are profound issues to consider in evaluating the relevance of such work for your specific applications of hypnosis. Some of them have already been raised in this and previous chapters, but others will receive attention in future chapters for you to consider as you evolve your own style of thinking about the clinical practice of hypnosis. At the very least, though, you are now aware that suggestions given in hypnosis can have a powerful effect not only psychologically but physically as well.

FOR DISCUSSION

1. What are some of the questions you have about brain functions in hypnosis that you think research may eventually be able to answer? Which ones, if any, do you think no amount of research will ever be able to answer? Why do you think so?
2. Why do you think people are attracted to scientific sounding descriptions of hypnosis (e.g., alpha state, theta state) that more often cloud issues than clarify them?
3. In your opinion, is it a reasonable assumption that if you correct "faulty" brain wave patterns the associated problems will also be corrected? Why or why not?

THINGS TO DO

1. Have a session or two with a biofeedback or neurofeedback expert. How might this approach be helpful to some people?
2. Pass an everyday object around the room, and have each member of the class generate a novel or unintended use for it. What do you discover?

CHAPTER 5

MATTERS OF THE MIND

The neurophysiology of the brain in hypnosis is undeniably a fascinating realm of inquiry. To the clinician wanting to apply hypnosis in treatment, however, the more immediate consideration is how a person's brain gives rise to a person's mind. What characteristics of mental functioning influence people's ability to respond meaningfully to clinical hypnosis?

Exposing individuals to standardized tests of hypnotizability yields overwhelming evidence that not everyone is equally hypnotizable, even with the most flexible of approaches to induction and the broadest definitions of hypnosis. What do we know about the relationship between conscious and unconscious mental processes and hypnosis?

In the most general sense, the primary rationale for employing clinical hypnosis is to access, organize, and mobilize a client's personal resources for therapeutic purposes. *Personal resources* covers a lot of ground. Some of these resources are consciously available to individuals, that is, generally in their awareness and easily accessible. Clients may know from previous experience that they can focus on breathing, for example, and thereby become more relaxed. Some of these resources are unconscious, generally outside people's awareness and perhaps even unknown to them. Clients simply didn't know about their ability to generate an anesthesia or an age regression because it had never been suggested or experienced before. It is first discovered through the hypnosis session and helps expand their positive sense of resourcefulness. Thus, characteristics of both conscious and unconscious processing become immediately relevant in the pragmatics of forming and delivering suggestions to clients absorbed in hypnosis. In this chapter, we consider some of these characteristics.

INFORMATION PROCESSING IS A MULTIDIMENSIONAL PHENOMENON

While there are different theoretical and philosophical frameworks for describing and explaining the phenomenon of hypnosis, there is a broad base of agreement within the field as to what Ernest Hilgard (1973) called the *domain of hypnosis*, referring to the various hypnotic induction procedures and the phenomena they give rise to, such as posthypnotic amnesia and perceptual distortions. People absorbed in the experience of hypnosis are able to organize and utilize their mental processes differently. Conscious awareness becomes more acute, and unconscious processes become more accessible. Consider John Kihlstrom's (2008) definition of hypnosis in this regard:

> Hypnosis is a process in which one person, designated the hypnotist, offers suggestions to another person, designated the subject, for imaginative experiences entailing alterations in perception, memory and action. In the classic case, these experiences are associated with a degree of subjective conviction bordering on delusion, and an experienced involuntariness bordering on compulsion. As such, the phenomena of hypnosis reflect alterations in consciousness that take place in the context of a social interaction. (p. 21)

Kihlstrom's definition employs words like *delusion* and *compulsion*, which may seem extreme to some if considered out of context, but his use of these terms simply speaks to the intensity of the person's experience in hypnosis, the degree to which someone may be capable of responding to suggestions. The role of attention in catalyzing hypnotic experience was described in the previous chapter. When individuals focus their attention and become experientially absorbed, suggestions are responded to simultaneously but differently on multiple levels. This is the principal observation leading to Hilgard's development of his influential neodissociation model, described in Chapter 3, which emphasizes multiple cognitive controls working on multiple levels.

Practically speaking, some of what one experiences during hypnosis may not be recognized or retained in awareness; persons form responses outside of awareness, such as smiles or frowns in response to specific suggestions or internal experiences, such as memories, that arise. Furthermore, people may consciously remember little or nothing about the hypnotic experience after ending the hypnosis session, a common phenomenon called *posthypnotic amnesia*. The fact that meaningful responses to suggestions can occur with little or no conscious involvement is some of what gives hypnosis the aura of "magic." It is a curious thing, indeed, when clients follow a suggestion given during hypnosis that they have no recollection for having received or no conscious understanding for how a response, like numbness in a part of the body, was achieved. For hypnosis purists like Weitzenhoffer (2000),

such nonvolitional responses to suggestion define hypnotic responding. Rather than being reflective of magic, however, such nonvolitional or unconscious responses reflect the capacity to respond to environmental stimuli without necessarily having to be aware of them.

One of the most intriguing aspects of training people to develop focus in their lives through hypnosis is how the phenomenon of automaticity surfaces during the process. Tobis and Kihlstrom (2010) described automaticity as composed of "effortless execution and parallel processing.… In principle, automatic processes do not interfere with other ongoing processes precisely because they do not consume attentional resources that are required by those other processes" (p. 369). One simply cannot be aware of everything all at once; thus, having the ability to carry out goal-directed activities without conscious effort is essential. Someone does not need to be consciously focused on a goal to still be operating in a goal-directed manner.

Many people use the general term *habit formation* to explain how something that is repeatedly performed consciously may eventually become automatic—that is, an unconscious, dominant response. Yet one of the most common observations documented in the hypnosis literature is how, even on the basis of a single hypnotic experience, a new perceptual or behavioral response is readily absorbed and repeatedly acted upon for a time span that may range from only a short while to an entire life span.

THE NEW UNCONSCIOUS: HOW AWARE ARE WE REALLY?

To even begin to address the phenomenon of automaticity, we must briefly transition into the domain of cognitive psychology. Professor of psychology and cognitive scientist James Uleman (2005) provided an overview of how cognitive psychology is changing some of our understandings of the unconscious and, in so doing, our understandings of ourselves:

> … The development of cognitive science across disciplines … discovered a great deal about complex unconscious mental phenomena and provided rigorous methods for studying them.… The new unconscious is much more concerned with affect, motivation, and even control and metacognition than was the old unconscious. Goals, motives, and self-regulation are prominent … and the new unconscious includes the causes of the phenomenal experience of having intentions and free will, of attributing these to oneself and others. (p. 6)

As Uleman alluded to, the evidence is growing that, as much as we like to think we can be in control of our judgments and behavior, in fact we are largely influenced by automatic cognitive processes that shape our responses

to life experience. These automatic processes influence what we like and dislike, how we perceive other people, how we react emotionally, and how we orient to the goals we establish (Bargh, 2006). Consider the unconscious power of "self-fulfilling prophecies" and placebo and nocebo effects.

Cognitive scientists consider it an attribution error to see self-control and free choice where we are acting out of unconscious and even unknowable forces. In fact, University of Virginia professor Timothy Wilson (2004), in his book *Strangers to Ourselves: Discovering the Adaptive Unconscious* (p. vii), wrote:

> People possess a powerful, sophisticated, adaptive unconscious that is crucial for survival in the world. Because this unconscious operates so efficiently out of view, however, and is largely inaccessible, there is a price to pay in self-knowledge. There is a great deal about ourselves that we cannot know directly, even with the most painstaking introspection.

How much of our own unconscious can we become aware of and regulate? Cognitive scientists make a distinction between automatic and controlled mental processes. With some exceptions, nonconscious thinking is regarded as automatic, and most conscious thinking is considered controlled, requiring attention and awareness. Is more attention and awareness an illusion? Perhaps so. Daniel Wegner, author of *The Illusion of Conscious Will* (2003), wrote in Wegner (2005) that we are most likely to believe we are doing something when three principles are in play: (1) a *priority* principle, which states that intentions precede actions; (2) a *consistency* principle, which states intentions and actions are consistent with each other; and (3) an *exclusivity* principle, which states that there are no other obvious causes of action besides the intentions.

Ruud Custers and Henk Aarts (2010) of Utrecht University in The Netherlands published an article challenging the conventional view that the decision to act produces the actions themselves. They showed that, under some conditions, actions are initiated even when we are unconscious of the goals for which we are striving or how these goals motivate our behavior. As psychologists Steve Jay Lynn and Joseph Green (2011) pointed out, "Because most people are unaware of the automatic nature of their responses … they tend to attribute the automatic or involuntary nature of their responses during hypnosis to an altered state of consciousness, trance, or the power of the hypnotist" (p. 284). Why is this important? For many reasons, but especially because the interaction between therapist and client triggers a wide variety of responses on many different levels, most of which are likely to be—and remain—unconscious. Here is an important and illustrative example of how what hypnosis practitioners think they are doing and how they explain what they are going to do may be quite different from what they actually do. Considering the earlier discussion of our conscious limitations and what may well be an illusion of free choice, it makes good sense both philosophically and therapeutically to

employ methods that encourage not only greater awareness but also the use of unconscious resources.

A principal means of studying the relationship between the unconscious exposure to specific stimuli and the influence of those stimuli on later behavior and perception has been through the study of *priming*. Priming involves exposing experimental subjects or clients to words, images, or even objects in the environment, at levels outside of conscious awareness, then exposing them to some task where the unconscious influence might be observed in their responses. For example, in one study (Epley, Savitsky, & Kachelski, 1999), graduate students in psychology were asked to generate topics for possible research. The researchers then exposed the students to subliminal images—brief flashes on a screen delivered too quickly to notice consciously—of either the smiling face of a friendly colleague or the obviously dissatisfied face of their faculty supervisor. Next, they were asked to evaluate the merits of the research topics they generated. With no conscious understanding of why, the students who had been exposed to the dissatisfied face typically rated their own ideas more harshly than those students who had been exposed to the smiling face. What does this suggest? It suggests, at least in part, that a stimulus with an affective valence (i.e., an emotional component) can affect one's emotions and perceptions at an entirely unconscious level. The emerging field of affective neuroscience is already providing interesting insights regarding emotional states, neurological functioning, and the decision-making strategies people employ.

One recent study (Williams, Bargh, Nocera, & Gray, 2009) may have profound implications for the practice of hypnosis in particular. It addressed the question of how likely someone is to reach a goal when the goal is nonconscious compared with when the goal is consciously pursued. When individuals were primed to be goal oriented nonconsciously for the purpose of encouraging emotional regulation, their behavior was every bit as goal oriented as those who had consciously oriented themselves to attaining that specific goal. The researchers wrote, "Across a variety of goal contingents, non-consciously operating goals have been found to produce the same outcomes, and in the same manner, as when those goals are consciously pursued" (p. 847).

This point speaks to how hypnosis can help in clinical contexts, where goals are set and may be worked on achieving on both conscious and nonconscious levels. So often, people who have gone through clinical hypnosis describe how important changes seemed to "just happen."

Verbally Shooting in the Dark

What complicates matters substantially is the inability to predict what might serve as an agent of priming. It is often the case when conducting guided meditations or formal hypnosis sessions that you simply do not know which

words, which phrases, which images, which realizations will be the ones to have a lasting therapeutic impact. I can offer suggestions that have specific goals in mind, and just as often as not the client generates responses that were not necessarily intended by me. Perhaps more remarkable is how often the responses they generated were more sophisticated than what I had in mind. Thus, I have come to appreciate how important it is to use hypnosis strategies as a vehicle for *creating possibilities*, allowing for the possibility that individuals' responses may well be the most useful one for them.

In using hypnotic patterns, suggestions may deliberately be formed in an effort to convey meaning to clients at nonconscious levels while their conscious awareness is occupied elsewhere. Thus, acknowledging the differences between conscious and unconscious characteristics is immediately relevant to the formulation of effective suggestions.

CONSCIOUS AND UNCONSCIOUS CHARACTERISTICS

The conscious and unconscious each have a different set of functions but also share a considerable number of functions between them (Hilgard, 1977; Oakley & Halligan, 2010; D. Spiegel, 2008). The overlap allows them to work together, while the differences can and sometimes do surface in internal conflict. The conscious has the ability to analyze things, to reason, and to make judgments as to what is right or wrong. The conscious ultimately decides what is possible to do and what is not possible to do, although such decisions may well be—and usually are—based on influences perhaps from past experiences, cognitive styles, or personality dynamics that are largely unconscious (Eisen, 2010; Yapko, 2010). Thus, it has been said, most notably by Milton Erickson, that many, if not most, of the limitations in one's life are based on a rigid conscious appraisal of experience.

We all have the ability to seek out or create experiences that challenge our beliefs or expectations, if we so choose. In fact, isn't that how personal growth takes place? You tell yourself you can't, circumstances require you to, and then you happily discover you could. It doesn't always happen that way, of course, but it happens often enough to highlight that if you believe in your expectations noncritically they can easily become your reality (Kirsch, 1990b). If you challenge them, your vision of what's possible grows. Hypnosis can work on both levels: boosting a conscious willingness to challenge oneself; and minimizing unconscious interferences that are the basis for being unnecessarily self-limiting.

How many things can you pay attention to at one time? Awareness is limited to just a few things at one time, and if too much comes in at once the mind selectively attends to whatever is given high priority based on personal values, motivation, experience, and other such factors. *Selective attention* is

a characteristic of hypnosis, a narrowing of attention to the clinician's communications. Beyond the hypnotic interaction, selective attention is a general characteristic of human information processing. Since we cannot pay attention to everything at once, the world is reduced to a manageable level through our conscious and unconscious selection of focal points. Communication to absorb and occupy clients' conscious mind is the starting point in the hypnotic interaction; such communication is called an *induction*.

Unconscious Processing in Hypnosis

The unconscious is, metaphorically speaking, a reservoir of all the multidimensional experiences acquired throughout your lifetime, including your historical experience, personal and social learnings, manner (drives, motivations, needs) for interacting with your world, and maintaining your automatic functioning in countless behaviors each day, from breathing to digesting to adjusting how you're sitting. The unconscious is capable of responding to implications and symbolic interpretations, not just what is said but also what might be heard "between the lines" of what is said.

If you are deeply engaged in what you are reading here, then you are either entirely unaware of the routine things occurring around you or you have some limited awareness for them but choose not to respond to them because you do not want to be distracted from reading. If someone else is nearby and calls you by name, for example, perhaps you do not hear her at all. Or perhaps you hear her in the "back of your mind" but are too involved in reading to respond; you'd rather not divert your attention. And when she finally calls you for the fourth time and yells, "Hey! I'm talking to you!" you may be aware that you heard her all along.

Simply put, people can take in and respond to information at levels outside of awareness, and hypnosis seems to amplify this process. While clients are in hypnosis, their conscious mind will naturally wander from thought to thought. They may well report having "lost track" of you and whatever you were saying. During those periods of time that can be long or short, their unconscious can—but doesn't necessarily—still take in the clinician's suggestions and is still quite capable of forming responses to them. Clients might not remember some or all of the suggestions given (amnesia), yet the suggestions may still exert an influence on them. Interestingly, many times my clients will come back, or call, quite some time after our hypnosis session and describe to me "new" insights and learnings that have caused a beneficial change in their experience of themselves. When they tell me what they've realized, almost word for word it will be things I said to them during our hypnosis session. But for them, the important learning is experienced as arising "spontaneously" from within. The resulting sense of personal empowerment is one of the many benefits of clinical hypnosis.

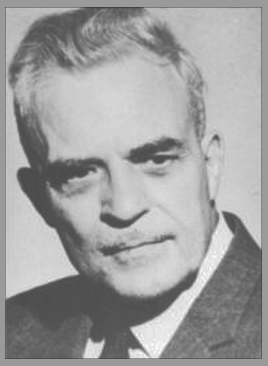
The Unconscious and Symptom Formation The metaphorical nature of the unconscious mind may be more easily understood when we consider the nature of symptoms. How does a person develop a particular symptom? Why do two different people under similar stresses develop different symptoms? There are many different viewpoints, of course, as to why people develop symptoms. For some, it's about genetic predispositions, for some it's about conditioning, and for others it's about maladaptive or ineffective coping strategies.

Some clinicians think of symptoms as metaphors for clients' experiences. For example, a symbolically oriented therapist might interpret a person's obesity as a protective layer of fat used for deterring unwanted sexual advances or as a pattern of "swallowing anger." Symptoms are thus viewed as unconsciously formed and therefore as indirect though purposeful. Therapy generally takes the form of trying to provide clients with interpretive insights about their unconscious needs or motivations to maintain the symptom. In short, they try to bring unconscious information into the client's consciousness to be critically dismantled.

This raises an interesting clinical issue: Should the therapist make interpretations about the presumed unconscious meaning of a client's symptoms? How many different ways can a symptom like obesity be plausibly interpreted? The clinician's role is not necessarily to impose his or her solutions on clients; rather, it can be to help clients find their own solutions. Realistically, imposing one's values and beliefs on clients to some extent is an inevitable byproduct of forming the therapeutic relationship, but it is best minimized, in my opinion, while maximizing respect for their integrity.

Treatment at Unconscious Levels The late psychiatrist Milton H. Erickson was an instrumental force in shaping modern psychotherapy. He evolved a style of treatment that operated on the premise, in part, that if a symptom may be metaphorical, so can its treatment be, innovating both direct and indirect approaches to the use of hypnosis and psychotherapy that were aimed at nonconscious aspects of experience (Erickson & Rossi, 1979; Haley, 1973; Zeig, 1980). His work continues to be enormously popular with clinicians for its practicality and ingenuity.

Erickson argued convincingly that the opportunity to communicate with clients' unconscious in hypnosis through a variety of suggestive mechanisms is a more respectful approach to addressing their needs without necessarily having to confront directly their conscious fears and limitations. Furthermore, he asserted that such communication is more respectful of clients' personal integrity because it does not force the clinician's values into clients' conscious mind by demanding conformity to the clinician's beliefs or theories. Rather, such communication allows clients the opportunity to keep unconscious whatever they wish to and likewise to make conscious what they care to. The clinician's responsibility is to utilize (hence the name *utilization approach* for Erickson's style of intervention) clients' choices in the process of treatment



FRAME OF REFERENCE: MILTON H. ERICKSON

Milton H. Erickson (1901–1980) is considered by many to be the most innovative and influential figure in the modern practice of clinical hypnosis and psychotherapy. His unique background, perspectives, and approaches to treatment are of nearly mythic proportion, having become the focal point for recent generations of hypnosis practitioners through the scores of publications and countless conferences and workshops advancing his methods.

Dr. Erickson's personal history was remarkable. His is the classic tale of "the wounded healer" and is well described in the book edited by Betty Alice Erickson and Bradford Keeney (2006) called *Milton H. Erickson, M.D.: An American Healer*. He was born color-blind and tone-deaf and suffered from dyslexia. He worked hard to transcend these limitations and did so with obvious distinction. Raised on a farm in Wisconsin, Dr. Erickson developed an appreciation for the simple and practical early on in his life. Tragically, he was stricken with polio at age 17 and nearly died. Paralyzed and unable to move anything more than his eyelids, he had a lengthy and difficult recovery. He often commented later what a good teacher the polio had been, forcing him to relearn the most basic patterns of movement and perception. In later life, he suffered post-polio syndrome and eventually lost the use of both his legs and one arm, thus confining him to a wheelchair. Yet his spirit was unbroken, and the many distinguished scholars who came to study with him right up to the very end of his life were awed by his stamina and grace in the face of intractable pain from the residuals of the polio, which, incidentally, he managed with self-hypnosis.

In the 1920s, Dr. Erickson attended the University of Wisconsin and as an undergraduate was exposed to the work of Clark L. Hull, an extremely influential experimental psychologist and expert on hypnosis. Dr. Erickson reacted strongly to the ritualized, impersonal, and inflexible approaches to hypnosis he saw Hull and others doing. He evolved a profound awareness of individual differences between people and developed practical ways to acknowledge and use those individual differences in the course of therapy. Consequently, Dr. Erickson's work has had a widespread appeal to clinicians in particular, who have found his emphasis on

the unique attributes of each person a respectful and necessary way of organizing therapeutic interventions with hypnosis. Dr. Erickson further popularized the use of more natural, conversational approaches to hypnosis that employed indirect methods such as storytelling and paradox. Dr. Erickson's optimistic belief that people had unconscious resources that could be organized and directed for therapeutic purposes has led to the development of an impressive array of methods of hypnosis that strive to actualize his optimism.

Dr. Erickson published extensively and lectured widely. Not all of Dr. Erickson's ideas have held up to the rigors of modern scientific inquiry, but the great majority of his teachings have proven to be not only clinically effective but also fundamentally correct. His emphases on achieving specific treatment results, involving family members in treatment, and the necessity of the clinician to be an active agent in creating contexts of change, all revolutionary concepts a half century ago, are now standard parts of treatment. Dr. Erickson's use of strategic task assignments, which often seemed strangely unrelated to clients' presenting problem because they were so indirect in form, have also become mainstream as current research evidence affirms the therapeutic benefits of behavioral activation. One literally cannot be a serious student of clinical hypnosis without studying the genius of Dr. Erickson's work in detail.

So popular is Dr. Erickson's work among clinicians that the Milton H. Erickson Foundation, organized in 1980 by psychologist Jeffrey K. Zeig, holds regular national and international meetings devoted to Dr. Erickson's methods. These are consistently the largest meetings held anywhere in the world on the subject of clinical applications of hypnosis. Furthermore, the Foundation serves as the "hub of the wheel" for the more than 130 Milton Erickson Institutes located all over the world, each dedicated to spreading Dr. Erickson's ideas and methods ever farther.

Unlike nearly all the other distinguished individuals featured in the Frame of Reference sections in this book, Dr. Erickson passed away before I had the chance to meet him personally. The following quotes are taken from a variety of sources noted at the end of each quote.

On empowering clients: "Properly oriented, hypnotic therapy can give the patient that necessary understanding of his own role in effecting his recovery and thus enlist his own effort and participation in his own cure without giving him a sense of dependence upon drugs and medical care. Indeed, hypnosis offers the patient a sense of comfort and an attitude of interest in his own active participation in his therapy" (Rossi, 1980, p. 34).

On the role of the clinician: "In hypnosis what you want your patient to do is respond to an idea. It is your task, your responsibility, to learn how to address the patient, how to speak to the patient, how to secure his attention, and how to leave him wide open to the acceptance of an idea that fits into the situation" (Erickson & Rossi, 1981, p. 42).

On confident expectations: "Every effort should be made to make the subjects feel comfortable, satisfied, and confident about their ability to go into a trance,

and the hypnotist should maintain an attitude of unshaken and contagious confidence in the subject's ability. A simple, earnest, unpretentious, confident manner is of paramount importance" (Rossi, 1980, p. 18).

On words and meanings: "Now, every word in any language has usually a lot of different meanings. Now, the word 'run' has about 142 meanings … the government can run. A run of luck in cards. The girl can run. A run of fish. A run in a lady's stocking. A road runs uphill and downhill, and still stands still.… And so, you ought to be acquainted with the linguistic patterns of your patients" (Zeig, 1980, p. 78).

On recognizing individual differences: "And I do wish that Rogerian therapists, Gestalt therapists, transactional analysts, group analysts, and all the other offspring of various theories would recognize that not one of them really recognizes that psychotherapy for person #1 is not psychotherapy for person #2. I've treated many conditions, and I always invent a new treatment in accord with the individual personality" (Zeig, 1980, p. 104).

On hypnosis and changing people: "It is hardly reasonable to expect a hypnotized subject, upon the snap of the fingers or the utterance of a simple command, to develop at once significant, complex, and persistent changes in behavioral functioning. Rather, it is to be expected that time and effort are required to permit a development of any profound alterations in behavior. Such alteration must presumably arise from neuro- and psychophysiological changes and processes within the subject, which are basic to behavioral manifestations, and not from the simple experience of hearing a command spoken by a hypnotist" (Rossi, 1980, p. 50).

On putting the patient first: "You see, I think the important thing in working with a patient is to do the thing that is going to help the patient. As for my dignity … the hell with my dignity. (Laughs) I will get along all right in this world. I don't have to be dignified, professional. I do the thing that stirs the patient into doing the right thing" (Zeig, 1980, p. 143).

On getting clients to do strange task assignments: "That is what my family says: 'Why do your patients do the crazy things you tell them to do?' I say, 'I tell it to them very seriously. They know I mean it. I am totally sincere. I am absolutely confident that they will do it. I never think, 'Will my patients do that ridiculous thing?' No, I know that they will" (Zeig, 1980, p. 196).

On orienting the patient to the future: "Insight into the past may be somewhat educational. But insight into the past isn't going to change the past. If you were jealous of your mother, it is always going to be a fact that you *were* jealous of her. If you were unduly fixated on your mother, it is always going to be the fact. You may have insight, but it doesn't change the fact. Your patient has to live in accord with things of today. So you orient your therapy to the patient living today and tomorrow, and hopefully next week and next year" (Zeig, 1980, pp. 268–269).

On how to live a long life: "Do you know a good recipe for longevity? … Always be sure to get up in the morning. And you can insure that by drinking a lot of water before you go to bed" (Zeig, 1980, p. 269).

(Duncan, Miller, & Coleman, 2001; Yapko, 2001a; Zeig, 1980, 2001; Zeig & Rennick, 1991). In that sense, Erickson's approach is highly individualized and client centered.

Milton Erickson's influence among clinicians has been profound, and many of his ideas have been amplified by clinicians who are prominent in their own right. The Mental Research Institute (MRI) of Palo Alto, California, was one of the earliest and most influential think tanks in the world of psychotherapy. The founding members of MRI were widely known and admired for their innovations in short-term treatments and were instrumental in bringing clinical hypnosis, family therapy, and strategic therapy into mainstream practice. The MRI included such luminary early members as Gregory Bateson, Richard Fisch, Jay Haley, Donald Jackson, Virginia Satir, Paul Watzlawick, and John Weakland. All of them advocated strongly for the value of hypnosis in their work. Jay Haley's classic book *Uncommon Therapy: The Psychiatric Techniques of Milton H. Erickson, M.D.* (1973) helped spark the revolution in psychotherapy's moving toward producing timely results rather than engaging in endless analysis. In Paul Watzlawick's classic book *The Language of Change* (1978), he described eloquently the need to communicate with the unconscious of clients to be as influential as possible in therapeutically altering their experience. Rather than the intellectual, rational jargon that appeals to clients' conscious minds, Watzlawick asserted that language that is descriptive, emotional, and appealing to the senses will likely make greater contact with their powerful unconscious resources.

What about the other side of the coin, though? Can hypnosis be used to "bypass conscious awareness" as some suggest and thereby leave clients defenseless against the hypnotist's suggestions?

IN DEFENSE OF THE MIND

The fact that information can be and often is processed with little or no conscious awareness leads some to be concerned that destructive or harmful information from the hypnotist is going to be taken in and damage clients. Can people be negatively influenced? Yes. Unquestionably, therapy is not an innately benign process. It can be iatrogenic, causing harm. It is wise to bear in mind the simple truth that anything that has the potential to help also has a potential to harm. But one does not need hypnosis for this to occur, nor does hypnosis carry any additional hazards associated with its use: therapists can offer well-intended advice that backfires, can provide misinformation with unintended consequences, can react irrationally to clients and their issues, can misdiagnose, can be overly rigid in their methods, and can cause harm in numerous other ways as well. It's why I cannot overstate how important it is to be a well-trained and appropriately credentialed clinician before jumping in to trying to help people. No one intends to damage clients, but

too many people get worse as a result of treatment rather than better. It's not the hypnosis that was the problem in such cases. Rather, it's what was said or done by the practitioner during hypnosis that caused either direct or indirect harm.

Despite this general warning, in general, the mind has an uncanny ability to protect itself. Every student of psychology, and anyone who has spent some time in the company of other people, learns about the classic defense mechanisms people employ to ward off threats from entering consciousness. The classic defenses such as repression, projection, rationalization, sublimation, and all the others are unconscious coping mechanisms; no one consciously says, "I can't accept responsibility for my feelings so I think I'll attribute these feelings to that person over there" (e.g., projection). The defense mechanisms are unconscious, rooted in the person's need for higher self-esteem and the desire to avoid internal conflict if at all possible. These defenses are certainly relevant to hypnosis.

There is a substantial difference between suggestibility and gullibility (T. Barber, 1969; Lynn & Kirsch, 2006). For individuals who are motivated to sensibly gather and weigh information and to consider the relative merits of what they are being told, hypnosis does not preclude the ability to do so. For someone who conforms to others' judgments, even obviously incorrect ones as discussed in the consideration of social psychology's relevance to hypnosis (in Chapter 8), hypnosis will not amplify either the willingness or need to do so.

All individuals are as psychologically safe as they want, need, or choose to be. If someone wants to reject suggestions, no matter how deeply absorbed in hypnosis, the ability to do so is retained. A "deeper" hypnotic experience doesn't increase compliance. The defenses someone can employ are both conscious and unconscious, so even suggestions that escape conscious scrutiny can still encounter unconscious defenses.

As a final point it seems to me that if there were a group of powerful humans called "hypnotists" who could control others through manipulation of the unconscious mind, hypnosis would be a uniformly successful tool in practice. It isn't.

THE MYTH OF A BENEVOLENT, ALL-POWERFUL UNCONSCIOUS

With a large and ever growing body of good evidence that clinical hypnosis is helpful in treating so many types of problems, there has been a growing but noncritical acceptance of the admittedly attractive belief that any problem can be solved, any condition or disease cured, if the "healing powers of the unconscious" are appropriately tapped. Some popular advocates of hypnosis

have made some rather extreme statements because of their enthusiasm. They tout the "wonders and unlimited capabilities of the unconscious mind," asserting that being in deep hypnosis and receiving the appropriate suggestions will magically resolve nearly every problem. They tell stories to their clients during hypnosis and instruct them to "trust your unconscious" to derive the therapeutic meaning. They offer suggestions and tell clients to "trust your unconscious" to effortlessly integrate them. They tell clients to be patient in allowing therapeutic progress because they can "trust the unconscious" to know when the best time will be to change. These practices are highly questionable. If only it were the case that all you have to do is offer a sensible suggestion to people's unconscious and then sit back to wait while their unconscious mind magically takes it in and puts it to work. Life as a clinician would be so much easier if that were the case.

The philosophy of a powerful and benevolent unconscious is appealing for many reasons. It's nice to think that each person has a core of health and power. It's nice to think our fundamental nature is positive and goal directed. It's encouraging to think we know at some deep nonverbal level what is right and true and that we should just trust our intuition. It's reassuring to believe that when we get sick with even life-threatening diseases that we can find the cure inside that's just waiting to be unleashed.

The belief in an all-powerful unconscious inspires optimism in many people that they find spiritually satisfying. It parallels how people couldn't get enough of the recent runaway best-seller *The Secret* (Byrne, 2006), which told readers that positive thoughts are magnets for attracting wealth, health, and happiness. Likewise, people love the motivational speakers who tell us we can "have it all." It sounds great. Unfortunately, it's just not true. We can have a lot, but no, we can't have it all. Why? Simply because every choice precludes other choices. If you choose to sit and read this hypnosis text, it means you're not at the movies right now. Thus, a primary goal of therapy with or without hypnosis is to increase the range of choices available to people and help them choose more wisely. Having a magical view of the unconscious simply doesn't foster greater skills in making good choices.

The "unconscious" is a global construct that psychologists, psychiatrists, and neuroscientists use to talk about parts of human functioning that take place beyond conscious awareness. It's an abstraction, shorthand. There isn't really a well-defined entity called "the" unconscious that we can say predictably and reliably does this or that. Instead, we infer principles of its functioning from scientific experimentation and careful observation. From this we learn that the unconscious has some impressive resources and potentials. We also learn that unconscious processes can lead people to make some pretty serious mistakes, certainly enough to warrant skepticism about those approaches that encourage people to simply "trust your unconscious." One can still be enthusiastic about hypnosis without overstating what it can do or, more accurately, what the unconscious can do through hypnosis. The impressive results speak

for themselves, but the belief that anyone can achieve easy, magical results is potentially quite misleading.

CONCLUSION

However you conceptualize the mind, there is a multidimensionality present. Conscious and unconscious dimensions of the mind each have some unique characteristics as well as some overlapping ones, and each offers its own contributions to the gestalt of subjective experience. Given the complexity of the human mind and the uniqueness of each human being, respect for the personal power and integrity of each person is not just desirable in clinical applications of hypnosis but is also essential.

FOR DISCUSSION

1. Why do people transmit messages incongruously? Should it be assumed they are being deceptive in doing so?
2. How do you characterize the key differences between the conscious and unconscious minds?
3. Do you trust your unconscious mind? Why or why not? Do you trust your conscious mind? Why or why not?
4. Do you believe in an "inner healer?" Why or why not?

THINGS TO DO

1. Have one person talk to you for a minute, then two people simultaneously, then three simultaneously, and so on. At what point do you feel overwhelmed in trying to attend to each? What can you conclude from this exercise about the attentional capacities of the mind?
2. Make a list of five common disorders, and then make a list of underlying feelings or motivations for which the problem may be metaphorical. For example, a weight problem may be viewed as individuals surrounding themselves with fat for protection against some threat. How do you determine whether your interpretation of a symptom is really what that symptom is about?
3. Collect newspaper and magazine ads that perpetuate the myth of a benevolent, all-powerful unconscious accessible through hypnosis. Discuss the merits and liabilities of each.

CHAPTER 6

CONTEXTS OF HYPNOSIS

One of the questions I am most frequently asked is, "Can hypnosis be used in the treatment of such and such?" I used to think I should instantly be able to cite a host of scientific studies to support my typically affirmative response, but I have changed tactics in recent years. Citing studies doesn't make the larger point I think needs making when someone wonders aloud about the applications of hypnosis. Now I am more likely to counter with questions such as, "Do you think there is any mental or emotional involvement with that disorder you are asking about? Do you think people's attitude, expectations, or belief system plays a role, however major or minor, in their experience of the problem? Are individuals' feelings, personal needs, or self-image a factor in the way their problem is experienced?" In routinely asking people such questions, I can't recall anyone ever responding, "No, the person's frame of mind is not a factor at all." Most people seem to readily grasp that even when problems are clearly physical in origin, they affect mood, outlook, expectations, relationships, behavior, and more.

Essentially, my response to the question of whether hypnosis can be used in the treatment of some particular disorder promotes the general idea that hypnosis can be used as a tool in the treatment of almost any human condition in which a person's attitude is a factor. Pragmatically speaking, the research evidence, though growing exponentially and generally affirming this point, is much less abundant than the anecdotal evidence described by generations of clinicians applying clinical hypnosis with almost every condition you can name. One has to be cautious regarding this issue, not wanting the claims to go beyond the evidence.

Thus, even if the disease is an entirely organic one, such as a physical injury, the person's mental resources can still be focused to help manage

discomfort more easily and perhaps even to enhance the healing process (Benham & Younger, 2008; Ginandes, 2002; Kroger, 2008; Rossi, 2000). In physical disorders where there is no known path to recovery, clinical hypnosis can ease the discomfort, allow some rest, encourage a positive attitude, and lessen any associated emotional trauma. Hypnosis may not facilitate a cure for an illness, but it can still help the person on a variety of levels and in meaningful ways.

The role of cognitive and perceptual processes in the development of various psychological disorders is far more obvious. Perhaps this is the basis for a more widespread acceptance of hypnotic principles and techniques among psychotherapists compared to medical practitioners, evidenced by the (currently) higher percentage of psychotherapist members in hypnosis societies and in attendance at hypnosis conferences.

Wherever there is an involvement of the person's frame of mind in managing a particular problem, which is everywhere to one degree or another as far as I can tell, there is some potential gain to be made through the application of hypnotic patterns. With that point in mind, this chapter considers specific contexts where hypnosis may be used to facilitate therapeutic outcomes. The context for applying hypnosis, of course, encompasses all the reasons for doing hypnosis, ranging from why the client is there to determining what approaches to employ to defining what constitutes therapeutic success. Thus, a detailed consideration of contextual factors operating in your specific workplace is vitally important.

STAGE HYPNOSIS

Stage hypnosis is the application of hypnosis for the purpose of entertaining an audience. I have already shared my distaste for stage shows because of the way they misrepresent and trivialize hypnosis. I described in detail the dynamics of how stage hypnosis shows work in Chapter 2.

MEDICAL HYPNOSIS

The quantity and quality of literature describing the applications of clinical hypnosis to a broad array of medical problems have been steadily increasing, and supportive empirical evidence for its therapeutic value is growing as well (Elkins, Jensen, & Patterson, 2007; Néron & Stephenson, 2007; Stewart, 2005). Some of these specific applications were described in the previous chapter. For others, you are encouraged to refer to the various scientific hypnosis journals in which such research is published. Some of these are mentioned in Appendix A.

In general, hypnosis can be a useful adjunct to more traditional medical treatments for several reasons, the first of which relates to the mind–body relationship and the role of the mind, including attitudes and related emotions, in medical disorders (Barretta & Barretta, 2001). Stories of "miracle cures" that defy current medical understanding, which seem to have evolved out of a patient's refusal to give up, are not uncommon to find in the literature. Pragmatically speaking, why not permit "miracles"? We can't and shouldn't promise them, of course, but there's no reason we should place limitations on patients that they would not place on themselves. I have been surprised and mystified too many times by things clients are able to do that, in theory, aren't possible.

A second reason for making use of hypnosis in the medical context is because of its inherent emphasis on the responsibility of all individuals for their own health and well-being. The use of hypnosis gives people a direct experience of having some control over their internal experiences, whether of pain or distress. I have worked with many people over the years who actually cried tears of joy or relief in a session for having had an opportunity to experience themselves as relaxed, comfortable, and positive when their usual experience of themselves was one of pain and despair. Finding resources of comfort or the ability to shift their perceptions of their body was a dramatic experience and encouraged them to take on a new and higher level of responsibility for themselves and their well-being.

Specific applications of hypnosis in medical contexts are greatly varied but can generally be described as a way of attaining a significant degree of control over physical processes. One possibility is the reduction or elimination of pain without the use of medication (Jensen, 2011a, 2011b; Patterson, 2010). Pain management is one of the more sophisticated uses of medical hypnosis and is applicable to the patient in both chronic and acute pain. Chapter 25 focuses on the applications of hypnosis in pain management. Hypnotic pain management techniques can be used to cope with debilitating diseases and injuries, before, during, and after surgery, to facilitate easier childbirth, and to help manage physical trauma of any sort. Methods of hypnotic pain management are generally very sophisticated, and you are advised to have a very strong background of education and experience in clinical hypnosis before working with individuals in pain. Treating people in physical pain presupposes appropriate medical licensure or appropriate medical supervision in all cases.

Hypnosis is commonly used in the effective treatment of anxiety and stress disorders, which can easily cause or exacerbate medical conditions. Teaching the medical patient techniques for preventing debilitating stress wherever possible, ways to identify stress and coping positively are all valuable in teaching hypertensive patients to skillfully manage their condition.

Traditional medicine has long recognized the "placebo effect." In some instances, patients' positive belief that they are getting an active, helpful drug (or other treatment) when she is really getting no drug at all, only a sugar pill

resembling a drug, will generate the same level of therapeutic effect as if the patient had been given an active drug. Conversely, negative expectations can foster a "nocebo" effect, a negative effect based on the belief the drug or other treatment will cause harm. A person's expectations and beliefs can obviously have profound effects on mental and physical experience. How hypnosis may amplify these effects is a dynamic field of inquiry.

Issues to Consider Associated With Applying Medical Hypnosis

There are a couple of special issues associated with hypnosis and mind–body healing approaches that I'd like to highlight. The first concerns patients' responsibility for their health. The goal is to positively encourage people to use all their resources to help themselves. Pointing out individuals' responsibility for themselves is not meant to translate into blaming them for their condition. One of the most distressing things to arise from the recognition of patient responsibility is when the doctor, or other well-meaning health professional, further burdens suffering patients with some measure of blame for having caused their illness. It's not bad enough that they are sick—they are also told they caused it through some mismanaged issue. Professionals have said destructive and improbable things such as, "You're ill because you have unresolved feelings of anger toward your mother." They have even asked patients why they did this to themselves: "Do you have an unconscious need to suffer?" No, this is not the intent; personal responsibility in health care is positive; blame is not. Helping people feel guilty about having "made" themselves sick is a poor outcome of a careless interaction.

The second issue, mentioned briefly earlier, relates to the use of hypnosis in the treatment of medical problems. Specifically, unless you are a physician or have the proper training and credentials to treat a person's physical disorders, you may be working out of your field and inviting trouble for both you and your patient. If you want to assist someone in the treatment of a physical disorder, it is imperative from an ethical, legal, and humane standpoint that you are a licensed physician or have the support and involvement of appropriate medical practitioners. Hypnosis can too easily be misapplied to delay or even prevent people from getting appropriate medical treatment, simply because the practitioner erroneously presumed a psychological basis for a problem. You cannot simply assume, for example, that patients with migraines are "just stressed." With that symptom, and all others, patients should first have a thorough physical examination to determine, if possible, just what's going on. Furthermore, it's a good idea to have medical backup as you treat individuals with what may well turn out to be organically induced symptoms. You can call the patient's doctor directly and ask if your treatment plan will interfere with his or hers, at the very least. Rarely, if ever, will it interfere and treatment can be sensibly coordinated between you. Knowledge of medications the patient may be taking, the physical impact of his or her symptoms, and knowing

something about the condition's course and prognosis are all essential to effective suggestion formulation.

The growing use of hypnosis in a broad range of medical conditions is evidence of the influence of all those who have called for a more patient-centered practice of medicine. Physicians, to their credit, have generally evolved a style of practice that invites the patient to be an informed and active participant in treatment. Clinical hypnosis amplifies this partnership and thereby empowers patients to mobilize their own resources to supplement whatever other treatments they might also be receiving.

DENTAL HYPNOSIS

The powerful mind–body relationship evidenced in medical applications of hypnosis is also relevant to dental applications. Many of the desired outcomes sought in medical contexts are also desirable in the dental setting because of the physical nature of dental work: Parts of the body—teeth, gums, and associated structures—are under treatment. Furthermore, attached to every mouth under treatment is a human being whose attitudes about the work being done, the dentist, and the circumstances will affect the outcome of the intervention.

Dentists are aware, perhaps acutely, that many dental patients do not mark their calendar months in advance of their appointment and wait with eager anticipation for the big day to arrive. Far more common are patients coming for treatment who can be described as somewhere in between mildly reluctant and terrified. Helping patients reduce their anxiety about receiving dental treatment with a few well-chosen statements can make a huge difference in the outcome (Mackey, 2010; Thompson, 2004b). Clearly, one good dental experience—real or imagined—can skillfully be used as a prototype for future dental experiences. These persons may not eagerly await the next appointment, but they won't have to live in dread either.

A second good use of hypnosis in dentistry involves the use of pain management techniques. Many people either cannot or choose not to use chemical anesthesia (or analgesics) such as Novocain or nitrous oxide and prefer to rely on their own resources when undergoing dental treatment. Hypnosis techniques for creating the experience of analgesia or anesthesia allow patients to reduce to a more easily managed level the degree of discomfort experienced, and many are able to eliminate the discomfort altogether (Barber, 1977; Chaves, 1993; Mulligan, 1996).

Hypnosis in dentistry is also useful for its ability to assist in directing the flow of blood. With proper techniques, ones that really fit well with patients' experience of themselves, hypnosis can reduce blood flow to the area under treatment (Barabasz & Watkins, 2005; Holroyd, 1992). The result is a less traumatic experience for patients and greater clarity for the dentist in seeing what he or she is doing. A related use of hypnosis is for the enhancement of the

healing process following treatment. Use of hypnosis techniques involving the imagining of healing (e.g., images, feelings, and sounds associated with rebuilding, repairing, and strengthening) can both shorten the recovery period and allow greater comfort during that time.

Another use of hypnosis in dentistry has been to counter bruxism, or teeth grinding (Clarke, 1997). For example, in one study by Clarke and Reynolds (1991), bruxism patients were given suggestions to develop a greater awareness of and control over the muscles in their jaws. The results were quite impressive, as both bruxism and reports of pain were significantly reduced.

Finally, hypnosis to encourage better dental health practices has been successfully employed (Finkelstein, 2003; Kelly, McKinty, & Carr, 1988). Suggestions to increase time brushing and flossing can be given to encourage prevention of dental problems.

Many dental practices could easily incorporate hypnosis into treatment through the use of generalized relaxation tapes the patient can listen to through headphones during the dental procedures. Of course, better responses occur with more individualized approaches, but unusual is the dentist who has the time, interest, and means for the greater involvement in hypnosis such a practice would require.

FORENSIC HYPNOSIS

In decades past, hypnosis had frequently been used in the course of criminal investigations to refresh or enhance eyewitness testimony, whether that of a witness, victim, or suspect (McConkey & Sheehan 1995; Wester & Hammond, 2011). In light of the considerable research evidence that hypnosis was given more credibility in the domain of memory enhancement than it often deserved, a subject explored in depth later, hypnosis has lost much of its value as a forensic tool.

As a part of the investigative process, particularly when key information simply can't be obtained in any other way and with certain guidelines in place (e.g., video recording and nonleading phrasing of questions), hypnosis may still occasionally be used to facilitate persons' recall in an attempt to recover details of the crime they could not consciously remember (Wester & Hammond, 2011). Often, individuals' conscious mind is so absorbed in feelings (e.g., fear, fascination, confusion) during the experience of witnessing or being victimized by a crime that conscious memory is poor. Because of the multidimensional nature of human information processing, memories and details that may have escaped conscious detection may not have escaped unconscious processes of assimilation and possible later recall (Kroger, 2008; Scheflin & Shapiro, 1989).

A number of famous, or perhaps infamous, criminal cases have been solved through hypnotically obtained information. One such case, which many people

FRAME OF REFERENCE: WILLIAM S. KROGER

William S. Kroger (1906–1995) was one of the primary and most forceful early catalysts driving the development of the field of clinical hypnosis. Dr. Kroger became fascinated with hypnosis at an early age, and his interest endured throughout his long, distinguished career. He was inspired to be a physician out of compassion for people's suffering, and early professional influences nudged him in the direction of psychosomatic medicine when the field was still in its earliest stages of development.

Dr. Kroger was one of only a very few obstetrician-gynecologists in America practicing hypnosis and delivering babies through hypnosis in the mid-20th century. In fact, his 1954 film of a hypnotic childbirth was groundbreaking and is still remarkable to watch. Dr. Kroger was a cofounder of the Society for Clinical and Experimental Hypnosis and, together with Dr. Milton Erickson, also cofounded the American Society of Clinical Hypnosis. He also organized the Academy of Psychosomatic Medicine.

Dr. Kroger wrote the book that was long considered *the* book on hypnosis, *Clinical and Experimental Hypnosis in Medicine, Dentistry and Psychology.* It was reissued as a revised second edition in 2008. Since Dr. Kroger had been a personal friend and mentor, it was my privilege to write a new introduction to the book that would place his extraordinary work in historical perspective. In preparing the revised second edition, the hypnosis and childbirth film and the exceptional 1956 film of a thyroidectomy being done with only hypnosis as the anesthetic were digitized and included on DVD with the book. I believe every serious student of hypnosis should read Kroger's book and see his extraordinary films. Dr. Kroger authored and coauthored many other important works, including his 1976 book with William Fezler *Hypnosis and Behavior Modification: Imagery Conditioning.* Dr. Kroger's deep interest in ways the mind can influence physical responses in

particular led him to apply hypnosis in a wide variety of ways, but especially in pain relief.

His commitment as a clinician and teacher inspired many of the most prominent people in the field to help bring hypnosis into mainstream research and practice. Anyone who professionally practices hypnosis owes a great deal to Dr. Kroger, whose pioneering efforts paved the way for the field to grow to its current proportions.

On the origin of his interest in hypnosis: "My interest in hypnosis started in 1919. My father had a fur store in Evanston, Illinois. In order to stimulate business, he hired a professional hypnotist to hypnotize a woman as a publicity stunt in order to create interest in the Main Street Businessmen's Association. This, I can see as if it was yesterday. The girl's name was Florina, and she was dressed in purple flowing gowns and veils. And he, with the piercing eyes, approached her and said, 'Florina, sleep!' He stared in her eyes and she fell backwards and they put her in a coffin and buried her in the ground. I was a curious little cuss, and so I went by and paid a nickel to see this sleeping beauty in the ground. She lay there in a vault for two days, and I thought, 'Gee, that's fantastic!' On the third day, they dug her up. 'Florina, wake up!' She opened her eyes, she blinked, she stood up—it was the same thing you'd see on the stage today. So I went around to the kids in the neighborhood and I looked into their eyes and said, 'Sleep!' And to my amazement, half of them fell over. I did the usual things; like I could put pins in their arms, and I'd say, 'Jeez, I could be a doctor some day. This would be great for anesthesia.' So, I didn't realize that hypnosis was anything more than a stage tool until I got to Northwestern University. At Northwestern University, I met the late Dr. J. D. Morgan, whose book you may be familiar with on abnormal psychology. We had several lectures on hypnosis, and I said, 'My God, this is a scientific tool!'"[1]

On early prejudices against hypnosis: "I was the only doctor who was using hypnosis in the Chicago area. I was laughed at, ridiculed, vilified, and abused, and made to walk seven steps behind everybody else like I was a leper. I was persecuted by the Illinois State Medical Society for an exhibit. They were just against hypnosis [even just] the word.… The difficulties I went through … you don't know how difficult it really was! [For the first movie ever showing thyroid surgery done with only hypnotic anesthesia] … it was an historic moment. First one in the world, and we pulled it off! [The medical director] was sitting downstairs in his office, getting a 'blow-by-blow' description of how the surgery was going, hoping it was going to fail [because hypnosis was involved]. Individuals who have never gone through things like that can't understand it. See, today hypnosis has some respectability, but in those days, they said, 'Walk seven steps behind me, you're a leper!' They didn't want to associate with me; they said, 'You're a hypnotist.'"

On "trance" and hypnosis: "Most people refer to it as a 'trance.' It's not a 'trance.' To me, that term is like fingernails scratching on a chalkboard. That's the most ridiculous term for it. [Hypnosis] is a state of increased awareness. If you're more aware, whatever you hear is going to sink in better. If it sinks in better, you get a better response, whether it's hitting a golf ball or having an erection. As Bernheim

said, 'There is no hypnosis, only suggestion.' That's how I conceptualize it. I conceptualize it in terms of neural science concepts as a method of transmitting a message in a minimal noise environment. If the signal to noise ratio is reduced, the message is clearly received. No other living system can do [what humans can]. Ideas have representations and names. You can't say to a dog, 'Go to the toilet.' He doesn't understand 'toilet.' But a human can—and that makes humans unique, because they can manipulate symbolic communication. The cortex is uniquely different in a human than in any other living system. And it's that cortex that you get out of the way (in terms of its criticalness) that allows you to induce a feeling of belief. So, what is hypnosis? It's the induction of conviction. All these guys talk about 'hypnosis is this and that'—it's a very simple thing that's [been made] complex, enormously complex."

On inductions and beliefs: "Now, an induction technique is an interesting study on feedback control. I'd say, 'You are looking into my eyes, your eyes are getting heavy.' They're not getting heavy because of what I'm saying. They're getting heavy because of the fact that he is gazing up at the ceiling. But the subject imputes to you a magical omnipotence, and he says, 'My God, my eyes did get heavy! This guy's got power!' If he accepts A, B, C, and D suggestions, then he'll accept X, Y, and Z ones. All the time you say, 'You are a good hypnotic subject and yes, that's why that happened.' And all the time, it had nothing to do with what the operator was saying; it had more to do with restructuring his beliefs."

On cybernetics and hypnosis: "I'm going to continue to emphasize the cybernetic principles of feedback systems relative to theories of hypnosis, as well as some of the very important neuropsychophysiological aspects by making the computer analogies. The brain functions like a computer. I'm not saying the brain is a computer—I'm only saying I think we can better understand the brain's chemical qualities and neurophysiological mechanisms in terms of cybernetic principles and feedback mechanisms."

[1] *Personal communication, April 10, 1987.*

will recall, that received national attention was the "Chowchilla Kidnapping" case in which a school bus driver and his bus full of students were kidnapped in the small town of Chowchilla in northern California. Three men commandeered the school bus and drove it to a nearby rock quarry where it and the people inside were buried. Then they issued a ransom demand. Somehow, the bus driver managed to escape. Dr. William Kroger, a true pioneer and longtime expert contributor to the field of hypnosis, was called in to use hypnosis with the driver, who was then able to recall the license plate number (though numbers were reversed) of one of the kidnappers' vans and where the rock quarry was. This hypnotically obtained information helped lead to the children's rescue and the kidnappers' arrest and subsequent conviction for the crime. Dr. Kroger's knowledge of hypnosis was formidable; besides his long career in practicing medical hypnosis, he was also so knowledgeable about its

forensic applications that he was the first person to teach hypnosis to government agency investigators at Quantico.

The use of hypnotically obtained testimony in the courtroom is still embroiled in controversy. Experts are at odds over the issue of whether hypnotically obtained testimony is valid because of the potentially detrimental effects of hypnosis on memory, particularly intentionally or unintentionally suggested memory distortions. On one side of the issue are those who claim that the information obtained from a hypnotized person is as usable and reliable as any other information obtained from memory and that hypnosis does not necessarily distort memory any more than memory naturally distorts itself. On the other side are those who claim that hypnosis invariably alters memory, that hypnotized witnesses can lie while in hypnosis and are likely to fill in missing details either with fantasy material or with information assimilated through the subtle leading questions of the investigator. When this happens, they can be absolutely sure of the memory's accuracy yet be absolutely wrong about it. Psychiatrist and hypnosis expert Herbert Spiegel used to call this the "honest liar syndrome" since individuals did not intend to misrepresent what happened.

The issue is really one concerning the nature of memory. In fact, both views—hypnosis can yield reliable memories and hypnosis can yield unreliable memories—regarding hypnosis are correct. The conflict is a pseudoconflict, a conflict arising because of its "either–or" nature, which is not a useful dichotomy in this case. All human memory is to some extent a distortion of experience since a memory is an internal representation of an event and not the event itself. The process of experiencing something and later remembering it is regulated by many factors. These include values regarding what is important to notice, mood, quality of internal or external focus, expectations, previous experiences in similar situations, and many other factors that must be considered.

Hypnotically obtained information should be considered in the same way as information obtained by any other means, in my view. It should be considered, evaluated, and substantiated by other means. If one has a motivation to lie, though, hypnosis has no preventive powers. If one must distort or misrepresent an experience, it won't be just because of hypnosis. One doesn't require formal hypnosis to fill in gaps or rely on others' leads; these processes are ongoing in all human beings. I fully agree with Australian memory and hypnosis researchers Peter Sheehan (1995) and Kevin McConkey (1992) that blaming hypnosis for the memory distortions is not reasonable when the evidence is clear that memory distortion is not unique to hypnosis.

Despite the accumulation of evidence that memory is unreliable in or out of hypnosis, the legal system is inconsistent in how it deals with hypnotically obtained testimony. Thus, it is extremely important that you take the time to find out how the courts where you live deal with this issue. Some have a "per se exclusion" rule that prohibits all hypnotically obtained testimony from being introduced into court proceedings, while other courts may allow it

within certain guidelines. Not knowing the law where you practice leaves you vulnerable in cases where you work with people who have legal proceedings coming up in their future.

The other potential use of hypnosis in the forensic context is to help alleviate the stress and distress associated with having witnessed or been victimized by a crime. A skillful practitioner can help lessen the trauma by easing people into a different frame of mind, by helping them shift their focus either away from what has happened to another experience or from one uncomfortable dimension of the experience to another that is relatively neutral at least, but positive if possible. The things one concludes and the things one says to oneself in the wake of a traumatic experience play a huge role in the rate and degree of recovery.

Special consideration for the emotional state of the person who recalls details of the trauma must be an integral part of the use of hypnosis in the forensic sciences. Mechanisms to assure the emotional security and well-being of the person must be part of the process, for being left alone to carry the hurt of memories brought out hypnotically is otherwise one more trauma for an already vulnerable human being (D. Spiegel, 2010).

HYPNOSIS IN EDUCATION

Teaching and learning are highly refined skills, both of which involve a great amount of information processing on multiple levels. Teaching is also a learning experience: learning how to capture students' interest and attention (a skill necessary for the induction of hypnosis, not coincidentally), learning how to present information in such a way that students can use it (a skill necessary for utilization of hypnosis, not coincidentally), and learning how to allow students to become self-sufficient learners (a skill necessary for consolidating treatment results with hypnosis, not coincidentally) so they may be competent and motivated to learn in the absence of the teacher. Whether a teacher is teaching preschoolers or doctoral candidates, effective teaching involves these steps paralleling hypnotic patterns.

Learning is also a multiple-step process. For the sake of simplicity—learning theory is a complex world in its own right—effective learning must include the following basic steps. First, there must be some degree of attentiveness to the material to be learned. Second, there must be some method for bringing the material from the outside world into the internal world. One's senses (e.g., sight, hearing) are the means for gathering information from the world around us. There is nothing we experience of the external world that does not enter our minds through one or more of our senses. Third, there must be some method for organizing the information internally as it assimilates with previously acquired information while also simultaneously building a framework in which

to incorporate future similar learning. Fourth, there must be some method for being able to retrieve the information from within as necessity dictates.

Does hypnosis enhance learning by enhancing memory? As you learned in the previous section, hypnosis does not seem to do much for enhancing accurate memory. Studies on using hypnosis to increase recall of meaningful as well as nonsense material generally reinforce this point (Erdelyi, 2010).

Hypnosis as a tool has been used successfully, however, to assist in the learning process both by enhancing concentration and diminishing anxiety. Anxiety can interrupt any of the previous steps, as in "going blank at exam time." Furthermore, poor concentration can distract one from having adequate exposure to the information as well as disrupt its internal organization (De Vos & Louw, 2006; Jacobson, Kramer, Tharp, Costa, & Hawley, 2011).

Many creative teachers at all academic levels are using hypnosis in their teaching, encouraging students' creativity and guiding students with relaxation and focusing procedures. Many students are developing themselves with self-hypnosis exercises, learning to manage anxiety, building frustration tolerance for learning challenging material, and increasing their ability to attend to and better organize their subject of study. Hypnosis in the educational context, whether formally or informally used, can enhance teaching skills, creativity, and student performance.

HYPNOSIS IN BUSINESS

In the business context, formal or overt hypnosis induction procedures are typically less applicable than is the use of hypnotic communication principles. Communication that influences people in meaningful ways is a vital component of any comprehensive view of hypnosis; in the business context applying the principles of effective communication can either make or break a company. Discussing specific skills in suggestion formation is the subject of later chapters; suffice it to say here that for businesspeople who are able to communicate their ideas in flexible ways to those with whom they interact, there is a greater likelihood of success at all levels. Communication skills in such interactions as presenting a marketing plan, handling of a troublesome employee or supervisor, conducting the job interview, carrying out performance evaluations, clarifying job standards and expectations, creating a desirable work atmosphere, and the many other dimensions of the business world are all ultimately interpersonal interactions where skilled communication and influence can and do occur.

In the business consultations I occasionally do, identifying rigid and dysfunctional communication patterns and replacing them with more flexible approaches helps enhance the business on multiple levels. I don't call my interventions "hypnosis" while there, but hypnotic patterns are likely evident to the trained eye when analyzing my methods and recommendations.

SPORTS HYPNOSIS

Engaging in athletics with any degree of intensity involves large measures of physical control and mental concentration. When former professional baseball player and team manager Yogi Berra famously said, "90% of this game is half mental," he may have mangled the verbiage but his idea was sound.

For the athlete, having precise control over one's body is essential to giving an outstanding performance. Athletes often describe what they call "muscle memory," the keen awareness of how each limb, each muscle must be positioned in order to perform successfully. The physical control through the amplification of the mind–body relationship can help athletes push their body to the upper limit of their talents. The requirement for intense concentration is obvious, and hypnosis as a technique for narrowing one's attentional focus to the task at hand is a powerful tool to have available (Liggett, 2000; Morgan & Stegner, 2008; Stegner & Morgan, 2010).

In addition to building concentration and physical control, hypnosis can help in better managing the tension inherent in competing. Furthermore, building positive expectations and positive communication with one's self through self-hypnosis can enhance performance dramatically. Often, the troubled, slumping athlete has mental images of failure, which all too easily get translated into real failure. Building positive images through hypnosis and self-hypnosis can turn an athlete's performance around completely. Certainly, hypnosis does not provide extra talent to athletes; it simply amplifies the talent they already have, giving greater access to as much of their talent as possible. A lot of athletes appreciate that, as you can well imagine.

HYPNOSIS IN PSYCHOTHERAPY

As a clinical psychologist by academic training and in practice, I have developed an especially profound appreciation for the possibilities hypnosis has to offer in the treatment of behavioral and emotional problems. Somehow, though, hypnosis has come to be considered separate from mainstream psychotherapeutic processes, as if suggestion and rapport weren't an integral part of every psychotherapy. Hypnosis as a part of therapist training programs seems an essential exposure to provide to students, yet only a handful of formal academic programs offer the opportunity to develop expertise in hypnotic skills. I think this is terribly unfortunate. Instead of learning to recognize and use suggestion skillfully, students are taught other things less central to the practice of effective therapy. Most people who become knowledgeable in hypnosis do so through involvement with workshops and seminars organized by private practitioners and professional hypnosis societies rather than through their graduate training programs. I hope that will gradually change.

Whatever training a clinical training program offers will indirectly include hypnosis because every therapy inevitably includes suggestion (T. Barber, 1985; Kroger, 2008). Unfortunately, though, without teaching the art and science of suggestion directly, many students do not learn to recognize the role of suggestion in their treatments. Even the classic hypnotic phenomena described in later chapters are evident in every therapy, but the concepts and uses for those phenomena are typically not taught. Why not? Simply because these phenomena have other names and characterizations in other models of psychotherapy. For example, the father of modern cognitive therapy, psychiatrist Aaron Beck, claimed he does not do hypnosis (personal communication, December 15, 1990). But he has no hesitations about encouraging his clients to close their eyes, relax, and focus on imagining themselves successfully carrying out some new behavior they're learning. He calls this a "success imagery." Structurally, however, he is doing an induction of focusing suggestions, he is orienting the person to the future, he is associating the person to new behaviors or thought patterns in some familiar context, and he is fostering a dissociation from old ineffective patterns. That is hypnosis. (For a detailed discussion of how hypnosis is evident in other therapies, see Chapter 26. To watch a video of a stimulating discussion between Dr. Beck and me about our ideas and methods of therapy, go to www.youtube.com and type in both our names in the search engine.)

Why use hypnosis to effect a dissociation and then look to unconscious resources for trying to help the client? It is a different way of doing therapy. But the person seeking help has quite likely already tried to consciously change (perhaps through sheer willpower or by seeking greater self-understanding from reading self-help books) and failed to do so. The resources people can get to consciously aren't the ones that have solved matters. In simpler terms, the perceptual frame they have used to solve the problem hasn't been helpful; the solutions are more likely to be outside their usual experience of themselves. Hypnosis helps people "step outside" their usual experience of themselves, allowing new associations to be formed in their inner lives, whether on cognitive, emotional, behavioral, or physical levels. Hypnosis by itself cures nothing. It's what happens during hypnosis that has the potential to be helpful to people.

Hypnosis in psychotherapy can be used in at least four general ways: (1) to suggest symptom relief; (2) to access and mobilize personal resources for enhanced problem-solving; (3) to teach specific cognitive, behavioral, relational, or emotional skills that can enhance self-regulation or improve situation management; and (4) to create associations and dissociations that allow for greater connection to or distance from specific elements of one's experience. How people use hypnosis clinically is a direct reflection of their beliefs about what causes peoples' problems and what constitutes appropriate clinical practice.

Hypnosis that involves simply performing an induction procedure and then giving suggestions for symptom relief is the most superficial and least

sophisticated use of clinical hypnosis. An approach can be superficial yet still be valuable. For example, insomnia is a common complaint of people suffering depression. Often, the insomnia arises from a pattern called rumination, the spinning around and around of troubling, stressful thoughts at bedtime. It is a superficial intervention to teach individuals to focus their thoughts on pleasant things when trying to fall asleep, but that is exactly what many people need and it makes all the difference in the world to them when their sleep improves. Since a symptomatic approach can and does work with many people, it is a viable choice to use in some therapies. Be aware, though, that this is only a small fraction of the potential usefulness of clinical hypnosis.

More complex and skilled applications of hypnosis involve persuasively introducing new and empowering perspectives to the client, a process called "reframing," teaching key skills that can be helpful in resolving current concerns and preventing future ones, if possible, and providing direct experiences that expand and enhance peoples' views of themselves, their resources, and their lives. Such experiences can be most profound for clients.

Use of hypnosis in the context of psychotherapy is a potent means for facilitating clients' movement toward a more empowered and satisfying existence. Practice with hypnotic techniques will demonstrate to you repeatedly the diversity, creativity, and power of people. That is one last great reason for its use; you will grow a lot, too.

In whatever context you choose to apply hypnosis, you cannot help but notice that the increased flexibility and sensitivity you demonstrate toward others and encourage in them will receive an appreciative response. It's an ideal "win–win" situation.

FOR DISCUSSION

1. Why do you think the mind–body relationship has been a divided one in Western society? What impact has this division had on people's attitude about health care?
2. What does "responsibility for one's health" mean? Do you agree or disagree with those who claim that all sickness is psychogenic? Why or why not? If you get a cold and people ask you, "Why do you let yourself get sick?" how do you answer? Is it a reasonable question in your point of view?
3. What ways can you think of to apply hypnosis in addition to those mentioned in this chapter? How might you encourage people working in that specific area to employ hypnotic methods?
4. Do you believe there are any contexts in which hypnosis should not be used? If so, why? What is the basis for your response?
5. What are the implications of calling hypnosis a "tool" and not a "therapy"?

THINGS TO DO

1. Review recent issues of the *American Journal of Clinical Hypnosis (AJCH)* and the *International Journal of Clinical and Experimental Hypnosis (IJCEH)* to discover the many ways hypnotic patterns are clinically used. These journals are likely to be available at the nearest university library. The *IJCEH* abstracts are available online by following the links at www.ijceh.com, and the *AJCH* abstracts are online by following the links at www.asch.net.
2. In your chosen field, what are the general assumptions you find the most limiting? Make a list of what things are and are not possible in your field as a direct consequence of these assumptions. For example, psychoanalysis does not generally allow for a rapid cure. How do you overcome such limiting assumptions?
3. Visit a bookstore or video store that sells motivational CDs or visit websites that offer hypnosis session MP3 downloads employing standardized hypnosis. How many different applications of hypnosis do you find? Ask the salespeople about these recordings or read online product reviews and learn people's reactions to them. What impression do you form?

CHAPTER 7

HYPNOSIS IN BEHAVIORAL MEDICINE

Amplifying the Mind–Body Relationship

The field of medicine has been going through a marked transition in recent years as increasing numbers of medical practitioners acknowledge and respond to the close relationship between the mind and body. This transition began somewhat reluctantly at first, simply because Western medicine had historically defined itself as a vehicle of treatment only for the physical body. Doctors were far more focused on the "broken hip in Room 205" than the person attached to that hip. However, the rapidly accumulating and irrefutable evidence made it clear that treating only the body was a misguided attempt to separate the essence of the person, including his or her mind and spirit, from the body. This separation proved potentially harmful, reducing the effectiveness of physical treatments or preventing them from working altogether. Research across many scientific disciplines has made it abundantly clear that virtually every problem, even those that seem "purely medical," are influenced by patients' mood and beliefs, which have measurable effects on both the course and prognosis of their condition. Thus, *mind–body medicine* was born and is now in its infancy. *Behavioral medicine*, defined as "an interdisciplinary field that uses the concepts and techniques of the behavioral sciences to

improve physical and emotional health" (Dictionary.com, retrieved May 30, 2011) has become mainstream as integrative medicine centers become increasingly common across the United States and around the world.

Hypnosis has had a special role to play in the evolution of behavioral medicine. From the late 19th century, in the early days of the famed neurologists Jean-Martin Charcot of the Salpêtrière Hospital in Paris and Hippolyte Bernheim in Nancy (France), and their young Viennese student Sigmund Freud, the power of suggestion to alter and even remove their patients' presumably psychosomatic symptoms (especially among those who suffered what most would now likely diagnose as somatoform disorders) was fascinating to behold. The early pioneers in clinical hypnosis were almost exclusively physicians who used suggestion to address not only psychosomatic symptoms but also diseases and medical conditions that were clearly organic in nature. They represented only a small fraction of the field of medicine, however, and were largely ignored and occasionally vilified by their medical colleagues, as William Kroger described so eloquently (see his Frame of Reference section in Chapter 6).

The obvious connection between mind and body has been on open display in the domain of hypnosis all along. Hypnosis was regularly used to demonstrate the capacity for altering sensory awareness, making pain control possible (the topic of Chapter 25). Hypnosis was also used to demonstrate increased control of the autonomic nervous system, influencing involuntary functions largely thought to be out of one's control, such as the reduction of stress hormone production (e.g., cortisol) through suggestion (Pawlow & Jones, 2002), the reduction in hot flashes in perimenopausal and menopausal women as well as many breast cancer survivors (Elkins, Marcus, Palamara, & Stearns, 2004), and the restoration of gastrointestinal functioning in patients with gastrointestinal disorders (Miller & Whorwell, 2009).

Much more recent is the discovery of the role of hypnosis in influencing gene expression, enhancing immune system function, and facilitating a better rate and quality of physical healing. Furthermore, hypnosis has been used to encourage active participation in treatment, what many physicians might term *treatment compliance*, as well as promoting other desirable self-management, health-oriented behaviors (e.g., quitting smoking, eating healthily, and exercising regularly). In this chapter, then, we'll consider the role of hypnosis in integrative medicine, exploring aspects of hypnosis that make it a desirable part of a multidimensional treatment plan as well as some of the ways it has already been successfully applied in behavioral medicine.

THE PLACEBO AND NOCEBO EFFECTS IN MEDICINE

The power of expectancy and belief, amplified through clinical hypnosis, is most dramatically on display through medicine's universal recognition of the

placebo effect. The *placebo effect* refers to an inert treatment given to patients or research subjects who derive benefit from the treatment simply because they expect or believe that it will work. Placebo effects have been studied most commonly in the use of drugs but have also been used in intravenous solutions and, even more dramatically, to study sham surgeries, where the patient is opened up but no actual surgical procedure is performed.

The term *placebo* was first coined by physician T. C. Graves in 1920 in an essay published in the medical journal *Lancet*. It's a Latin word meaning "I shall please." Henry Beecher, in 1955, published a seminal paper in the *Journal of the American Medical Association (JAMA)* called "The Powerful Placebo." He distinguished between what he termed *placebo reactors* and *placebo nonreactors* since not everyone reacts in the same direction or to the same degree (just as with hypnosis).

Placebo effects are easiest to demonstrate in those conditions where subjective factors are especially prominent, meaning the attitudes, beliefs, and expectations of the individual play a greater role in the types and magnitude of symptom. Thus, when the problem has a less clear and multicausal origin, placebo effects are likely to be larger. For example, some headaches, stomachaches, and types of back pain are more responsive to placebos than others. Depression and anxiety are also highly responsive to placebos. Patients are given an inert treatment, typically a sugar pill or "dummy" medication, that they believe is an active drug that will produce a therapeutic effect, and surprisingly frequently it does.

The quality of individuals' expectations or beliefs can also have the reverse effect, unfortunately. The term *nocebo reaction* was coined by Walter Kennedy in a paper published in 1961. He chose the Latin word nocebo, meaning "I shall harm" (the functional opposite of the word placebo) to describe an undesirable, injurious reaction to the administration of an inert treatment. Given a dummy drug, patients generate a negative reaction based on the belief that the drug is dangerous. They experience the inert drug as harmful and as the cause of unpleasant (or worse) side effects. Despite the fact that the drug is a dummy, the physiological, emotional, cognitive, and behavioral consequences, whether positive or negative, are quite real and can have a profound effect.

The power of belief in influencing treatment responses has a clear and direct relationship to the use of clinical hypnosis in the medical setting. The added value of having persons' minds and spirits align with the medical intervention they are receiving cannot be overstated.

Is Deception Necessary for Placebos to Work?

The fact that the unsuspecting person is given a dummy drug along with the direct or indirect lie that the drug is "real" has long been the subject of ethical debates in medicine and other concerned fields as well. The presumption has been that only by deceiving patients into believing the drug is active will the

relevant subjective forces be mobilized in the direction of generating a therapeutic response. However, a recent study conducted at Harvard University and Beth Israel Deaconess Medical Center (Kaptchuk et al., 2010) has challenged that assumption in a way that may surprise you: they tried the direct approach. A total of 80 patients suffering irritable bowel syndrome (IBS), a gastrointestinal disorder, were divided into two groups: (1) a control group that received no treatment at all; and (2) a placebo treatment group that were told to take one sugar pill twice a day. Both groups were then monitored for 3 weeks.

Those given the sugar pill were clearly and directly told it was a sugar pill, that it had no active ingredients whatsoever and was made from an inert substance. Incredibly, the word placebo was actually printed on the bottle from which they took the pills. Patients were told they did not need to believe in the placebo effect; they should just take the pills as prescribed. They did indeed take the pills, and those in the placebo group had nearly twice the reduction of symptoms as those in the no-treatment group. In fact, the relief that the placebo group members reported was equal to taking the most powerful IBS medications currently on the market. Doctor of oriental medicine and placebo researcher Ted Kaptchuk, the study's lead author, attributed the benefit to the "performance of medical ritual." The findings of Kaptchuk and his colleagues certainly raise questions about just how far placebos can go in treatment and what role in treatment deception may have.

Psychologist Irving Kirsch has been studying placebos and placebo effects for more than 2 decades. Kirsch has been a powerful advocate for the sociocognitive perspective of hypnosis, convincingly demonstrating empirically that much of individuals' response to hypnosis is determined by their expectations. What's a good hypnotic induction? What your client believes is a good hypnotic induction. What's a good therapeutic suggestion? What your client believes is a good therapeutic suggestion. An especially important aspect of Kirsch's work relevant to this discussion concerns his view of hypnosis as a *nondeceptive placebo* (Kirsch, 1994; Lynn, Kirsch, & Hallquist, 2008).

What does that mean, hypnosis as a nondeceptive placebo? Contrasting suggestions given in hypnosis with deceptive placebos given in medicine, Kirsch (1994) made the point that hypnosis leads people to alter their physiology, behavior, affect, and cognitions in line with the offered suggestions, but there is nothing hidden or misleading about the suggestions. Offering the suggestion that "you can begin to experience the same level of physical comfort as if you'd taken a strong pain pill" may provide full or partial relief by simply encouraging a possible response that clients *independently* find a way to actualize. The suggestion that "your headache can diminish and leave you gradually with each breath you exhale" simply and straightforwardly states a possibility for relief from the headache. It does not promise relief, it doesn't exaggerate the odds of the relief from the headache evolving, and it doesn't say exactly when the relief will be evident or how long it will last. But clients who are paying close attention, who are focused on the

clinician and the suggestions, who believe the suggestions accurately reflect a genuine possibility, and who feel empowered to respond in a meaningful way, albeit unconsciously, can generate relief from the headache much to their own satisfaction as well as that of the clinician.

The issue is a complex one. How direct and transparent should suggestions be? In Chapter 15, when we explore the different suggestion structures and styles in detail, I will point out that each suggestion style and structure has the potential to be beneficial with someone. Obviously, however, not all people react in the same way to suggestions, even those that are clearly in their own best interest. The artistry of effective hypnosis encompasses a detailed knowledge of the relationship between suggestion and expectancy effects that give rise to the best of hypnotic responses in the people you treat.

EPIGENETICS: THE MIND–BODY FRONTIER

Our knowledge of genetics has changed markedly in recent years, primarily due to the extraordinary success of the Human Genome Project (HGP). Begun in 1990 and completed in 2003, HGP was an exceptionally complex project that had the ambitious goals of identifying the 20,000 to 25,000 genes in human DNA (carried on the 46 chromosomes we all have) and determining the sequences of the 3.2 billion chemical nucleotide base pairs making up human DNA. While the average gene consists of 3,000 base pairs, the largest known gene to date (called dystrophin) has approximately 2.4 million base pairs. As of this writing, most of the genes have functions that are still unknown. (You can visit the Human Genome Project Information website at www.ornl.gov/hgmis/home.shtml.)

How an organism develops and sustains itself over its life span is regulated by a set of chemical reactions that switch parts of the genome (DNA) on and off as the need to adapt dictates. Epigenetics is the study of these chemical reactions and the environmental factors that affect them. "In its modern usage, 'epigenetics' encompasses all mechanisms for the inheritance of biological traits that do not involve alterations of the coding sequence of DNA" (Halfmann & Lindquist, 2010, p. 629). Thus, the HGP has clearly shown us that genes aren't destiny. A variety of environmental conditions are now known to affect gene expression. Perhaps the most obvious demonstration of this fact is evident in studies of the genetic changes in identical twins over the course of their lifetimes. The twins may have the same genetic makeup (genotype) yet show very different outward traits (phenotype), such as one suffering an emotional disorder the other does not: "DNA that was virtually identical at 50 days may have after 50 years become markedly dissimilar" (Feinstein & Church, 2010, p. 284).

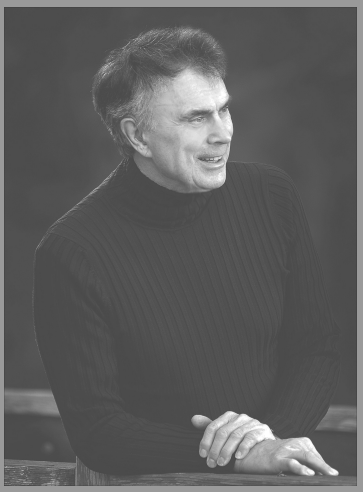
Specific to our consideration in this chapter of the role of hypnosis in behavioral medicine, does the use of hypnosis have any measurable effect on whether and how a gene expresses itself? Can hypnosis be considered an

environmental variable—an experience designed and delivered with therapeutic intent—that might have a measurable epigenetic effect? The evidence is growing that the answer is yes. How can we tell? One answer lies in a sophisticated technique for measuring gene expression involving DNA microarrays. These are *gene chips*, wafers lined with thousands of microscopic sequences of DNA that can assess the expression of any combination of genes in the human body during any physical activity. These DNA microarrays make it possible to "identify the activity patterns of gene expression at any given moment in any condition or state of health or illness" (Rossi, 2004, p. 40).

A team at Harvard Medical School conducted a study to discover the epigenetic effects of learning to develop relaxation skills using the model set out by Harvard Medical School Mind Body Medical Institute associate professor Herbert Benson in his book *The Relaxation Response* (2001). An experimental group that was untrained in relaxation was first compared with a group already well trained in relaxation. Then this group of untrained individuals was trained to produce the relaxation response over a 6-week span. When the newly trained group members were retested, their gene expression had changed to resemble those of the experienced relaxers. The relaxation skills had measurably and positively affected gene groups known to be involved in cellular regeneration as well as the production of antioxidants. Changes in the expression of 1,561 specific genes were counted as a result of the relaxation training (Dusek et al., 2008).

The use of clinical hypnosis is inextricably embedded within psychotherapy, given the transparent goal of striving to influence patients' frame of mind even when delivering a "purely" medical treatment. Every treatment offers suggestions, whether verbally or nonverbally, directly or indirectly. Separating suggestion from psychotherapy simply isn't possible. What effect does suggestion, applied in therapeutic context, have on genes? Feinstein and Church (2010, p. 284) claimed that "psychotherapy may impact (a) the expression of genes that cause a disorder, (b) genes that suppress a disorder or influence its severity, or (c) genes involved with maladaptive learning and conditioning." They further delineated five areas of biological change that take place in the course of psychotherapy: "Psychotherapy ameliorates: 1) exaggerated limbic system responses to innocuous stimuli, 2) distortions in learning and memory, 3) imbalances between sympathetic and parasympathetic nervous system activity, 4) elevated levels of cortisol and other stress hormones, and 5) impaired immune functioning" (p. 283). They go on to say, "The beneficial alteration of gene expression patterns may, in fact, be the biological common denominator among all successful psychotherapies" (p. 285).

Some genes may take hours to reach their peak expression after being activated, but others, called *immediate early genes*, can reach their peak expression



FRAME OF REFERENCE: ERNEST LAWRENCE ROSSI

Ernest Lawrence Rossi (1933–) is one of the most creative and deep thinkers in the history of hypnosis, seeing well beyond what most others have observed. He has powerfully catalyzed research into the mind–body relationship and has been at the forefront of the emerging field of epigenetics. He introduced health-care professionals to the notion of a "mind-gene" connection in his pivotal book *The Psychobiology of Mind-Body Healing* more than a quarter-century ago. Research is now beginning to confirm his view of the malleable relationship between gene expression and environment that determines whether and how a gene expresses itself. Dr. Rossi's insights have been drawn from epigenetics, functional genomics, psychophysiology, chemistry, physics, and mathematics. His uncanny ability to see relationships that have escaped others and to articulate them in his writings is a gift to everyone interested in using the mind to facilitate physical health and mental well-being.

Dr. Rossi is a psychologist, author, and researcher who earned his PhD in clinical psychology from Temple University. His BS was in pharmacy, earned at the University of Connecticut. His development of psychosocial and cultural genomics, what he understatedly calls "the deep study of meaning from mind to gene," will have a profound impact on our understanding of human experience on many levels. Anyone carefully studying Dr. Rossi's work learns there is a sound research foundation underlying his explorations of brain, mind, and body. He has been honored with three lifetime achievement awards for his outstanding contributions to the field of psychotherapy bestowed by the Milton H. Erickson Foundation (1986), the American Association for Psychotherapy (2003), and the American Society of Clinical Hypnosis (2008).

Dr. Rossi is author, coauthor, and editor of three dozen scientific books and more than 160 papers. His first book was the 1972 volume *Dreams and the Growth of Personality,* which illustrated the creative cocreation of mind, brain, dreams, and new consciousness. Many first became aware of Dr. Rossi through his creative and productive collaboration with Milton H. Erickson. Together, the two coauthored four extremely popular books that helped propel the newly emerging field called *Ericksonian hypnosis and psychotherapy* into orbit. He can be credited with helping define the naturalistic and utilization approach, as it is now known. He initially edited the four-volume set *The Collected Papers of Milton H. Erickson, M.D.* in 1980 and is a coeditor of an updated 16-plus-volume series of *The Collected Works* of *Milton H. Erickson, M.D* beginning in 2008 and expecting to continue into 2012. With his pioneering research in ultradian rhythms, our natural 90–120 minute basic activity–rest cycles of alternating stress and healing, Dr. Rossi helped establish the complex neurobiological, psychophysiological, and molecular-genomic foundations of therapeutic hypnosis. He has authored fascinating books on how mirror neurons mediate consciousness and creativity in human relationships (*The Breakout Heuristic,* 2007) and how experience-dependent gene expression and brain plasticity may be facilitated by therapeutic hypnosis (*The Psychobiology of Gene Expression,* 2002b*; A Discourse With Our Genes,* 2004b). There is no more important voice in the field of hypnosis describing mind–body healing than that of Dr. Ernest Rossi. You can learn much by reading some of his key papers by visiting his website (www.ernestrossi.com).

On his evolving interest in the molecular-genomic level analysis: "My father was an Italian immigrant to America who made his own wine in the cellar of our home. It was a deeply mysterious process to me as a 6- or 7-year-old when, much to the amusement of my family, I first became so drunk by the fumes of the fermenting wine that I could not climb the steps back upstairs. Later, as a 9- or 10-year-old shoe-shine boy, I saved all my tips to buy a chemistry set to learn about the magic of molecular transformations in wine and explosions. That eventually led to scholarships and graduate work in pharmacy where I never met a molecule I did not like. Later, as a [National Institute of Mental Health] NIMH postdoctoral fellow, I studied psychoanalysis with Franz Alexander, who was the international leader in psychosomatic medicine. From there, it was only a little hop and jump to Milton H. Erickson, whose innovative approaches to therapeutic hypnosis were revolutionizing mind–body medicine."[1]

On Erickson's influence and the transition to epigenetics: "With Erickson, psychosomatic medicine became mind–body healing. The essence of the connection between mind and body in neuroscience, which initially emerged in the 1970s when I was studying with Erickson, became 'activity or experience-dependent gene expression and brain plasticity in the 1990s.' The nature–nurture equation was then adopted by the new science of epigenetics: how the outer environment modulates activity or experience-dependent gene expression and brain plasticity. With David Lloyd, a professor in pure and applied biology at the University of Wales, I edited two profoundly scholarly volumes by an international cast of researchers in 1992 and 2008. These volumes focus on the deep biological basis

of ultradian rhythms and the 90–120 basic rest–activity cycle, which is required for a complete cycle of mind–body communication and healing. This is the molecular-genomic foundation of epigenetics in general and, I believe, the natural mechanism of mind–body healing that we utilize in therapeutic hypnosis. While everybody else was using a 50-minute hour for psychotherapy, Milton H. Erickson's sessions lasted 90–120 minutes. Why? I just put two and two together. The time and phenomenological patterns of Erickson's therapy were practically identical with the new neuroscience of experience-dependent gene expression and brain plasticity."

How hypnosis informs his views of the role of environment in modulating experience-dependent gene expression: "Since its conception by Mesmer and others centuries ago, therapeutic hypnosis has always been about the mysterious so-called alternative, complementary, or integrative approaches to healing that appeared to be outside the realm of mainstream of medicine. Traditional medicine was dominated by Rene Descartes' famous "Cartesian Gap": the separation of mind and body into two distinct realms. Traditional medicine excelled with physical concepts such as body, blood, bones, and tissues that were made up of molecules and genes. But, until now, we had no way of understanding how the mind and body are related in psychosomatic medicine. Our current concepts of epigenetics together with experience-dependent gene expression and brain plasticity do exactly that. As far as I know, it was Otto Georg Wetterstrand who introduced the term ideo-plastic in his 1902 book *Hypnotism and Its Application to Practical Medicine.* Almost a century later, in the 1990s, neuroscience adopted the term plastic to describe a number of remarkable discoveries that documented how novelty, enrichment, and exercise (both mental and physical) could evoke what they called 'activity or experience-dependent gene expression and brain plasticity.' In my 2002 book *The Psychobiology of Gene Expression*, I proposed that such neuroscience research was the molecular-genomic foundation of epigenetics in general and therapeutic hypnosis in particular."

On dissociation, ideo-plasticity, and hypnosis in healing: "Let me describe how I bring together the traditional dissociation theory of historical hypnosis with the new ideo-plastic theory of therapeutic hypnosis. I utilize the classical four-stage creative process to facilitate therapeutic hypnosis in my new protocol that is called the 'Creative Psychosocial Genomic Healing Experience.' The administration and rationale for this new ideo-plastic protocol as well as an open invitation to do further research is presented at www.ernestrossi.com/ernestrossi/Neuroscienceresearchgroup.html.

"I begin by asking the person, 'Which of your hands is warmer or cooler than the other?' This type of question, which I call an 'implicit processing heuristic,' initiates a state of focused attention, heightened expectancy, and intense mind–brain activity that is characteristic of therapeutic hypnosis. Such questions initiate a sensory-perceptual 'dissociation' between the opposites (warmer or cooler) that heighten the person's self-awareness, self-sensitivity, and potentials for self-healing. After a series of such dissociations (e.g., 'Which hand is stronger or

weaker?' 'Which hand seems to be you today—and which hand seems to feel more like you as a child?') a person gets closer and closer to the critical therapeutic dissociation, catalyzed by the question, 'Which hand experiences your issue (problem, symptom or whatever)—and what do you experience in your other hand that is the opposite of your problem?'

"Well, whatever is the opposite of a problem can be a hidden, inner, mind–brain resource that can initiate a path of inner psychodynamic activity, which I hypothesize can evoke activity or experience-dependent gene expression, brain plasticity, and psycho-neuro-immunology for resolving the problems. I then encourage the person to experience a fascinating, numinous, and wondrous inner psychodrama between the two hands that generates the ideo-plastic reconstruction of the problem to reframe and resolve whatever traumatic dissociation was the original source of the problem. Frequently, the hands mirror an intense activity-dependent therapeutic process that is the molecular-genomic signature of the so-called creative unconscious, which usually has the qualities of automaticity and adaptability characteristic of therapeutic hypnosis."

How his naturalistic/utilization concept of mind–body healing has changed: "I believe Erickson's two seminal papers on the naturalistic and utilization approach written in 1958 and 1959 (Erickson, 1958, 1959) together with his paper on 'The Burden of Responsibility in Effective Psychotherapy' (1964/1980) are the alpha and omega of his approach to therapeutic hypnosis and psychotherapy. In these papers Erickson shifted the locus of control from the therapist in the medical model to the client in the creative model of psychotherapy and therapeutic hypnosis. I simply noticed that the neuroscience of activity and experience-dependent gene expression and brain plasticity supplied the missing epigenetic molecular-genomic foundation of Erickson's naturalistic and utilization approach. I noticed how the phenomenology of the classical four-stage creative process in everyday life as well as in our numinous experiences of art, beauty, and truth could also evoke activity and experience-dependent gene expression and brain plasticity. My current research and clinical practice is all about facilitating this four-stage creative process of problem solving and mind–body healing with my activity-dependent, ideo-plastic hand mirroring approaches to psychotherapy. My ultimate dream? Could we invent a simple mind-gene transducer to make a practical mind-gene biofeedback device that anyone could use to facilitate their own wonders of self-healing?"

[1] *Personal communications, April 5, 2010, and April 23, 2010.*

in a matter of seconds. Future research will explore how hypnosis influences gene expression and how this translates into some of the most intriguing effects found in people, such as the shrinking or elimination of a malignant tumor and the acceleration of healing or the production of mystifying phenomena such as the controlled bleeding of wounds.

Psychologist Ernest L. Rossi is pioneering the efforts to study the epigenetics of hypnosis and their relevance for mind–body medicine. Rossi is especially intrigued with what he views as the defining characteristic of hypnosis: the *ideo-plastic faculty*, a term coined by Swedish physician Otto Wetterstrand in his 1902 book *Hypnotism and Its Application to Practical Medicine*. Wetterstrand's definition of the ideo-plastic faculty is "the power that ideas possess to influence physical conditions …" (quoted in Rossi, 2010, p. 64). The prefix *ideo* addresses the automaticity of a suggested response and will be addressed later when discussing the ideodynamic responses, the various automatic (i.e., nonvolitional) responses—including physical ones—that arise during the experience of hypnosis.

The salient question is, how is it that some people can be highly responsive to suggestion yet show limited ability to influence physical processes through mind–body applications of hypnosis while others can be highly responsive to suggestion and manifest remarkable shifts in bodily processes? The concept of ideo-plastic faculty as a mediator of response ability has obvious relevance in behavioral medicine. It invites more careful study of the factors that most influence the capacity for altering gene expression—and physiology—in hypnosis. Rossi (2010) developed a protocol for assessing the creative ideo-plastic faculty of therapeutic hypnosis: *the Creative Psychosocial Genomic Healing Experience (CPGHE)*. Through measurements employing DNA microarrays, Rossi uses the CPGHE to "document how therapeutic hypnosis can turn on experience-dependent gene expression and, by implication, brain plasticity" (p. 65).

MOOD AND MEDICINE

When someone suffers with medical problems, some related psychological issues will inevitably affect their course and prognosis. As Covino and Pinnell (2010) pointed out:

> Medical illnesses, conditions, procedures, and treatments are influenced by psychological factors and, commonly, influence them. Depression, anxiety, and anger are frequent sequelae to medical illness and have been implicated as important variables in illness onset.… Problems of psychophysiological arousal, behavior, affect, and the patient's intrapsychic and interpersonal world (i.e., *psychodynamics*) contribute, independently and interactively, to amplify autonomic nervous system activity and intensify medical symptoms. (pp. 551–552)

The biopsychosocial model (Engel, 1977) has been widely embraced for its recognition that biological, psychological, and social factors collectively play a

role in virtually all illness. Recent research has particularly highlighted the role of mood, especially the mood disorder depression, in exacerbating existing illness and increasing vulnerability (i.e., risk factors) for eventual illness. Once again, the power of psychology to influence physiology is on clear display.

Depression and Health

When suffering an illness, it is common to feel victimized, trapped in a body that is at least impairing one's ability to function normally and at most may be threatening one's very existence. Feeling victimized, out of control, in a way that is so deeply personal is an easily understandable pathway into feeling discouraged and even depressed. One's normal life stops, movement is restricted or blocked altogether, illness takes center stage in one's ongoing awareness, feeling bad physically is constant, the fear builds that life may never return to normal (if it ever was), and the feelings of despair and hopelessness can easily escalate into full-blown depression.

What effect does depression have on illness and vice versa? As general points to consider first, patients with chronic medical illness have been shown to have a high rate of depression (Katon, 2003). The relationship is reciprocal, for depression itself can give rise to unexplained or multiple somatic symptoms. In fact, somatic symptoms are the predominant reason depressed patients seek medical care (Kroenke, 2003).

Cardiac Health

It has been estimated that people suffering depression have a doubling of mortality at any age, independent of suicide, smoking, or other risk factors for poor health (Gold & Charney, 2002). Depression is associated with an elevated risk for heart disease. In one illuminating study of 2,900 participants ages 55–85, those who did not have heart disease at the start of the study but experienced depression had their risk of death from heart disease quadruple. For those patients who already had a history of heart disease, cardiac deaths tripled in those suffering from depression (Penninx et al., 2001). Depression increases the risk for heart attacks, for the heart attack being fatal, and for subsequent heart attacks if the first one is survived (Nemeroff & O'Connor, 2000). Depression appears to increase the levels of stress hormones, especially norepinephrine, which is toxic to tissues in general, but heart tissue in particular (Carney, Freedland, & Veith, 2005). Depression is linked to an impaired functioning of blood platelets, a decreased variability of heart rates, an increased cardiac fibrosis (stiffening of the heart tissue), a lowered immune response, and an increased probability of leading an unhealthy lifestyle (Kop & Kuhl, 2008; Penninx et al., 2001).

Neurological Health

Depression is found to coexist, called a comorbid condition, in a range of 20–50% among patients with stroke, multiple sclerosis, epilepsy, Parkinson's disease, and dementia (Kanner, 2005). In one study, for example, depression was found to increase the risk of ischemic strokes or transient ischemic attacks (TIA) by a factor of four, but only in subjects under 65 years of age (Salaycik et al., 2007). When the neurological event or disease has occurred, depression may easily set in and influence the course of treatment and recovery. According to the National Institutes of Health (NIH, 2002c), of the 600,000 Americans who experience a first or recurrent stroke each year, at least 150,000 (25%) experience major depression within 2 months as a result. Stroke survivors who are depressed may be less compliant with rehabilitation. Of the more than 500,000 Americans who suffer Parkinson's disease, NIH estimates that as many as half suffer from depression. Those with Parkinson's and depression, compared with those with Parkinson's alone, tend to show higher rates of anxiety, sadness, insomnia, nightmares, and suicidal thoughts (Borek, Kohn, & Friedman, 2006; NIH, 2002a, 2002b).

The literature on the relationship between one's general level of optimism or pessimism and health has been steadily growing. In a general sense, it is not much of a surprise to discover that happy people tend to live longer than unhappy people and to suffer fewer serious medical problems, as studies at Duke University Medical Center, Harvard, the Mayo Clinic, and others have reported (Brummett, Helms, Dahlstrom, & Siegler, 2006; Maruta, Colligan, Malinchoc, & Offord, 2000; Steptoe, Wright, Kunz-Ebrecht, & Lliffe, 2006; Vaillant, 2000, 2002). The link between smoking and depression, as just one example, is a robust clinical finding, and it makes sense: why bother to stop smoking if you believe you're just going to die anyway or that everybody's going to die of something? (Fergusson, Goodwin & Horwood, 2003; Trosclair & Dube, 2010).

APPLY CLINICAL HYPNOSIS TO EMPOWER THE MEDICAL PATIENT

Hypnosis in the medical context, what some therefore term *medical hypnosis*, can be used in a number of ways. Suggestions can be offered for (1) healing the disease or condition the patient is suffering; (2) modifying the disease or condition in some way (e.g., slowing its spread or reducing symptom severity); (3) reducing risk factors for the onset or exacerbation of a disease or condition (e.g., improving one's diet or frequency of exercise to prevent or better manage diabetes); and (4) enhancing one's coping skills to reduce one's level of distress (e.g., anxiety, depression, avoidance) associated with the disease or

condition (or procedure, such as a blood draw or injection). These applications are not distinct. To the contrary, any well-planned intervention is likely to encompass all of these possibilities to one degree or another. Each of these applications, when applied realistically so as to not build false hope, has the net effect of empowering patients, who can discover that even if they can't control the problem they can learn to view it differently in ways that can help make a meaningful difference.

The Danger of Unfounded Optimism: Learning to Create Possibilities

The issue about raising false hopes is especially important in health care. It is an exceptionally tricky issue to manage, since we want to establish the hope, belief, and expectation of improvement that channels patients' healing capacities in a helpful direction. Optimism can be a good thing, but it can also be hazardous. It is optimistic to believe that "I can smoke and won't get lung cancer" or "I can eat anything I want and I won't gain weight." But such blind optimism can simply fuel unhealthy behavior that works against the person over time.

How, then, to manage this delicate issue? First of all, it is imperative that you have a detailed knowledge of the condition for which you are treating the person. The patient's primary care medical doctor is usually the person in charge of the case, even when a team approach is utilized. Having talks with the patient's doctor is considered essential. Knowing what the rest of the treatment plan looks like and who else is involved in this patient's care and how your work with hypnosis might fit in can come only through shared information and perspective among caregivers. Second, by having a detailed knowledge of the condition you're attempting to provide some help with, from etiology (origin) to its course and prognosis, you're in a better informed position to know at least some of what to expect for this patient. You'll also know what not to do or suggest when you are aware of each disease or condition's unique characteristics. A lack of information can be a basis for inappropriate treatment. For example, suggesting to a multiple sclerosis patient that he imagine being in a warm, comfortable place—such as the beach on a hot day—can aggravate the condition because heat exacerbates symptoms. Doing some sound research in advance can make the difference not only between therapeutic success and failure but also between fueling false hopes, cruel to someone desperate for a molecule of hope, and providing compassionate, sensible care.

Since people surprise practitioners all the time (e.g., by living long past the time they were told they'd die, by having tumors shrink or disappear altogether), it's simply a good idea to keep in mind to *use hypnosis to create possibilities*. I don't know and can't know ahead of time just what this patient is capable of generating, so it helps to stay open-minded while finding out. Later, when you learn about permissive suggestion styles, you'll discover the

importance of talking to people in terms of what they might experience rather than promising them a specific result you really don't know they can produce or you can deliver. The point will be made many times throughout this volume that hypnosis provides a context in which people can discover hidden resources, latent abilities. *Hypnosis cures nothing.* What makes hypnosis *potentially* therapeutic is what happens *during* hypnosis: the new understandings that people develop, the new experiences that lead them to form a revised, more expansive image of the self, others, and life. I can't ethically or morally or even pragmatically promise patients that they will be cured of cancer. But I can talk about the possibility of feeling better, the potential need for less pain medication as their body gets stronger, and the growing sense of ease rather than dis-ease. My language is simply the language of possibility, and any benefits patients derive they are fully entitled to claim the responsibility for generating.

WHAT MEDICAL CONDITIONS CAN BE TREATED WITH HYPNOSIS?

Taking a biopsychosocial viewpoint to heart means acknowledging that any and every disease or condition has multiple dimensions and numerous variables that affect patients' quality of life. From this perspective, there are many possible points of entry into their inner world: expressing feelings, discussing the spiritual meanings, exploring trains of thought, considering the social effects, developing coping behaviors, managing pain and other distressing physical symptoms, mobilizing skills in relaxing and focusing for enhancing mind–body relationships, and so on. Where clinicians will jump in typically depends on their training and style of treatment. Fortunately, hypnosis sessions can be constructed to serve whatever specific goals the clinician has in mind.

It therefore seems fair to say that hypnosis can be used in the treatment of virtually any condition in which patients could benefit from becoming absorbed in a more adaptive way of viewing and managing their condition. To highlight this very point, in this final section of this chapter I will briefly mention just a very few of the diseases and conditions for which there has been a documented benefit from applying hypnosis. This will be a terribly abbreviated list, given the volume of information available in the scientific journals in which medical hypnosis research is published. You are urged to research the literature to learn how hypnosis has been applied to whatever specific diseases or conditions are of particular interest to you. But the point will be made abundantly clear from the cursory mention of some of the literature that the integration of clinical hypnosis into medical treatment plans doesn't just make good sense—it helps.

Hypnosis to Reduce Anxiety, Avoidance of Medical Procedures

A recent meta-analysis of 26 studies involving randomized controlled trials employing hypnosis for reducing distress related to medical procedures showed an overall large effect size in favor of hypnosis (Schnur, Kafer, Marcus, & Montgomery, 2008). Elvira Lang and her colleagues (Lang, Joyce, Spiegel, Hamilton, & Lee, 1996; Lang et al., 2000) reported on the use of hypnosis to reduce the discomfort in patients undergoing invasive diagnostic radiological procedures; patients reported significantly less anxiety, required less medication for pain, and were more likely to complete the procedures than those who were not trained in hypnosis.

Hypnosis for Pain Management

The volume of information attesting to the value of hypnosis for providing pain relief is extensive and will be described in detail in Chapter 25.

Hypnosis for Healing

Hypnosis has been shown to be valuable in a number of ways that relate to healing: shortening of hospital stays, reduced blood loss during surgery, and reduced stress associated with medical procedures (Lynn, Kirsch, Barabasz, Cardeña, & Patterson, 2000; Pinnell & Covino, 2000). Stress has been shown to delay wound healing and surgical recovery (Glaser, Kiecolt-Glaser, Marucha, MacCallum, Laskowski, & Malarkey, 1999). Hypnosis was tested for its ability to augment not only functional recovery but also structural healing. In a representative study by Carol Ginandes and her colleagues (Ginandes, Brooks, Sando, Jones, & Aker, 2003), women undergoing medically recommended breast reduction surgery who all went through the same surgical procedure and postoperative care were then randomly divided into three groups receiving either usual care (i.e., no psychological intervention), supportive attention, or hypnosis sessions specifically for a targeted acceleration of wound healing. The hypnosis group showed significantly more healing at the surgical site at 7-week follow-up than either of the other two groups. Surgeon Dabney Ewin, a pioneer in the treatment of burn patients with hypnosis, has extensively documented the use of hypnosis to facilitate tissue healing with such patients (Ewin, 1986; Patterson, Goldberg, & Ehde, 1996).

Hypnosis for Gastrointestinal Disorders

Miller and Whorwell (2009), both of the University of Manchester in England, provided a substantive review of the evidence for the therapeutic value of hypnosis in treating gastrointestinal disorders, especially IBS, the most common

GI disorder. The evidence suggests that "hypnotherapy offers patients with functional gastrointestinal disorders a 60% to 70% chance of substantial reduction in their symptoms that can last many years" (p. 288). Across many different studies, it is a consistent finding that hypnosis provided a significant reduction in symptoms, an improvement in quality of life, a reduction in doctor visits for IBS and other symptoms, and an ability to return to work (Gonsalkorale, Miller, Afzal, & Whorwell, 2003). Clinical psychologist and health researcher Olafur S. Palsson is associate professor of medicine at the University of North Carolina at Chapel Hill. He is a leading expert in the use of hypnosis in treating gastrointestinal disorders, particularly IBS (Palsson, 2006). He has established a website for disseminating relevant scientific studies and their implications and also generously shares his empirically validated protocol for treating IBS on his website (www.ibshypnosis.com).

Hypnosis for Immunological Disorders

Hudacek (2007) provided this succinct general summary of how hypnosis may alter the immune system:

> Although the exact signaling pathway of the brain's effect on physiological functioning has yet to be elucidated, general principles about the mind-body connection are well accepted. Overall, stress, such as that induced by a cancer diagnosis, is manifested as a negative mental state. It appears that the biochemical state of the brain influences sympathetic and hormonal signals, thus dysregulating the immune system of the body. Because hypnosis alters the cognitive perception of stressful events, it can reverse the downstream immune effects caused by stress. (p. 413)

The effects of hypnosis on enhancing immunity were examined recently in a study by Barabasz, Higley, Christensen, and M. Barabasz (2010) of patients genitally infected with human papillomavirus (HPV). HPV is the most commonly sexually transmitted disease (STD) in the United States and can lead to cervical as well as other cancers. The standard medical treatment is to treat the genital warts by removing them with either acid or surgery or by freezing them. Barabasz et al. contrasted hypnosis-only with medical-only therapies in urban hospital and rural community samples. Both approaches resulted in a roughly equal statistically significant reduction in affected areas and numbers of lesions. At 12-week follow-up, however, "complete clearance rates were 5 to 1 in favor of hypnosis" (p. 102). In a study by psychologist John Gruzelier (2002), professor of psychology at Goldsmiths College, University of London, 6 weeks of training in guided imagery in immune function in participants with virulent and chronic herpes-simplex virus-2 (HSV-2) "increased natural killer (NK) cell cytotoxicity to HSV, improved mood, and, most important clinically,

decreased recurrence" (Hudacek, 2007, p. 412). Using hypnosis to enhance immune system functioning to better resist cancer has been explored with some promising results. In two studies of women with early-stage breast cancer (Bakke, Purtzer, & Newton, 2002; Hidderley & Holt, 2004), both concluded that the hypnosis improved mood and elevated specific immune-cell levels in these patients.

CONCLUSION

The range of medical conditions that have been successfully helped with hypnosis is impressive. If we are to enlist patients' full participation in their treatment and to amplify the power of those enigmatic unconscious processes that respond to directions to alter physiology in therapeutic directions, then we need to have a knowledgeable and flexible clinician and patients who are open and willing to explore their potential in hypnosis. What is these individuals' ideo-plastic faculty or capacity to convert a suggestion into a dynamic therapeutic response? What is these individuals' capacity for using their mind to influence the body? This is one of the most exciting things about hypnosis. You don't fully know what people's capacities are before you begin the hypnosis session, so you have a chance for being regularly amazed by people generating responses that are nothing short of remarkable. When hypnosis is well applied, and patients' hidden hypnotic talents are provided a context for their emergence, they have the opportunity to discover and use personal resources of which they may have had no previous awareness. Many patients describe such a powerful discovery as life-changing, transformational, and enlightening. Many clinicians, awed by witnessing what their patients can do, describe it in the same ways.

FOR DISCUSSION

1. Are "purely medical" problems really only physiological? Why or why not?
2. Why do you think openly telling research subjects in the Harvard study by Kaptchuk et al. (2010) that they were taking placebos didn't diminish the benefits they derived?
3. What do you think about the view of hypnosis as a nondeceptive placebo?

THINGS TO DO

1. Interview physicians as to how often and under what conditions they administer placebos to their patients. Do they have any ethical concerns about deceiving people? How do they address these?
2. Research the topic of epigenetics in greater detail. What does the literature suggest to you about the possibilities in hypnosis?
3. Interview people about risky behaviors they engage in and how they perceive them as really not all that risky. How might optimism affect their judgment?

CHAPTER 8

THE SOCIAL PSYCHOLOGY OF HUMAN SUGGESTIBILITY

We live in a world populated with other people who have the potential to exert influence on us merely through the things they say and do, even if those things are not directed at us specifically. How other people influence our perceptions, reactions, and behavior is the domain of inquiry of the field of social psychology (Aronson, Wilson, & Akert, 2009). Social psychology studies the wide array of things that happen when people get together, whether in person or even electronically through the media or texting: how and why we are attracted to or repelled by others; what leads to love, aggression, conformity, prejudice, tolerance, cooperation, competition, loyalty, generosity; and the myriad other fascinating things that happen in the context of human relationships (Myers, 2009). In some very important ways, the literature of social psychology is more relevant to the practice of clinical hypnosis than is the clinical literature. It offers countless insights into the factors that make hypnotic interactions possible.

In this chapter, we explore the relevance of social psychology to the phenomenon of human suggestibility. What is it about human makeup that leads us to be so responsive to others? Mirror neurons, discussed in Chapter 4, provide a neurological basis for being responsive to others and highlight our fundamentally social natures. We are "wired" to connect with other people, and even our utter helplessness at birth highlights the social dependency we are born into. Thus, we must, of necessity, form bonds with others and evolve

patterns of relating to them that reveal the range and depth of our social requirements. From this standpoint, the ability to absorb information and perspective from others is basic to fulfilling our individual and collective needs. That doesn't mean absorbing all messages and all perspectives, of course. People learn to be selective as they evolve a sense of personal identity and a capacity for critical thinking. People are more easily influenced, too often to their detriment, when personal identity and critical thinking don't evolve.

The responsiveness to suggestions—that is, direct and indirect messages imparting information and perspective—and the associated vulnerability to the influence of others (and to self-suggestions as well) are the essence of human suggestibility. Suggestibility as a trait exists because all individuals recognize that they are limited; after all, no one person knows all there is to know about everything. No matter how knowledgeable you are in an area, your information remains incomplete. When we brush up against those areas we recognize we know little about, we tend to become more suggestible to the influence of others we believe may know more. While no one is entirely immune to the influence of others, clearly there is a range of responsiveness across people. As discussed in the next chapter, some people are more suggestible than others.

There are many different factors that mediate the phenomenon of suggestibility, one of which is the degree to which people believe it is necessary or desirable to be responsive to the suggestions of others. Some people are more self-directed, and others are more other-directed. Self-directed individuals are more inclined to follow their own ideas and behave more autonomously, perhaps not noticing or caring about the relevant social conventions or even flaunting them as a means of defining themselves as beyond the influence of others. Other-directed individuals are more sensitive to the reactions and feelings of others and are more likely to engage in approval-seeking and people-pleasing behavior in ways that seem to overlap with an increased responsiveness to others' suggestions. Thus, in the practice of clinical hypnosis, it becomes important to consider how self-directed or other-directed and open or guarded people are relative to the influence of others. The hypnotic context is obviously an interpersonal one, and social forces are relevant to appreciate its full potentials.

The relationship between hypnosis and suggestibility is still the subject of much debate and scientific inquiry in the field. Is hypnosis the same as suggestibility? Can we accurately say that hypnosis increases suggestibility and the evidence for hypnosis is an increase in suggestibility? This circular relationship between the phenomena of hypnosis and suggestibility is both apparent and perplexing: the hypnotist performs an induction, hypnosis occurs because people are suggestible, and people are suggestible because they're in hypnosis.

The relationship between suggestibility and the clinical benefits to be derived from hypnosis is an important domain of inquiry. If we strive to use hypnosis to

help someone in some clinical context, we certainly want to know our therapeutic suggestions are having a beneficial impact. Is suggestibility simply an individual personality trait that exists in stable form across different contexts? If so, then determining someone's level of suggestibility in one way or another will make sense to the clinician. If individuals are deemed suggestible, then they will absorb suggestions. Or is suggestibility determined by additional factors beyond just people's capacity to respond to suggestion, such as the salience of a suggestion, the context in which it is delivered, or the demeanor of the people who offer it?

These questions can be answered: Suggestibility is not a stable trait across all situations. How someone responds to tests and retests of hypnotizability scales may show a relative stability of hypnotic responsiveness to the scales over time, but this is not the same as suggestibility across life situations. Someone may be quite suggestible in one situation or with one particular person but not at all with another. There is a selectivity that increases or decreases responsiveness to suggestions based on many different factors, described in this chapter as well as throughout the book.

THE ILLUSION OF THE INVISIBLE CLINICIAN

Some clinicians are of the belief they can do therapy or do hypnosis without influencing the dynamics of the process. For example, they think they can hypnotically "dig" for hidden memories without influencing the quality of memories that emerge (Calof, 1993; Fredrickson, 1992), or they think they can be therapeutically neutral by refusing either to take sides with a family member or to offer a client direct advice (Rogers, 1986; Sanford, 1987). Is it realistic to believe you can interact with the client yet not be part of the interaction? To believe you can be in a therapy relationship with someone yet play no role in what happens in that relationship is a potentially hazardous illusion. It makes it possible to claim no responsibility for what happens if and when the therapy goes awry.

Hypnosis in the clinical context is invariably a directive approach, meaning it is purposefully applied with a therapeutic goal in mind. Influence is an overt goal, not a hidden agenda. Some clinicians may have difficulty with functioning as an agent of influence if they hold the philosophy that influencing clients is somehow wrong or undesirable. This philosophy has dwindled over the years as psychotherapists have been less attracted to the humanistic therapy's notion of the "therapist as a mirror." It seems therapists have grown more comfortable with the responsibilities to educate, direct, inspire, challenge, and support clients in distress. Consistently answering a question ("Doctor, what do you think I should do?") with a question ("Well, what do *you* think you should do?") is an abdication of those responsibilities.

To believe you can do therapy or clinical hypnosis with clients—by definition an interpersonal process—yet elicit only their intrapersonal dynamics ignores the roles of the clinician and the social context in the process. Such a perspective also allows the illusion to persist that therapeutic effectiveness is entirely in the technique rather than the relationship that provides the context for making the technique viable. This is yet another good reason to avoid the use of scripted hypnotic approaches.

Let's take a look at social influence in specific contexts.

THE INFLUENCE OF ADVERTISING

In America, many billions of dollars are spent yearly on advertising products and services. Does all that advertising really work? To the corporations who budget hundreds of millions or even billions of dollars annually for television commercials, radio and magazine ads, Internet pop-ups, and direct mail ads, the answer is clearly yes. Advertisements come at us relentlessly from all sides, and we tend to absorb them whether or not we consciously realize it. Once absorbed, they can influence our buying habits. Why do you buy the products you buy when you shop? How do you choose one brand over another? Why are you likely to feel you are making a sacrifice if you buy cheaper house brands or plain wrapped brands instead of the familiar name brand you really want because of its perceived greater attractiveness (Myers, 2009)?

Advertising as an industry makes great use of suggestive techniques to attempt to influence you to buy a product. How do advertisers do this? They typically begin by creating a need for a product. They may acknowledge an existing need, or they may create one: for example, how can you carry your all important cell phone around in that drab generic case? You must have a personalized cell phone case, one that reflects your personality and interests, a dazzling case that others will notice and admire. Then advertisers use techniques such as promoting an identification with the person in the ad so you'll realize you can solve your problem by using the product in the same way it was modeled for you: "Look at how much happier this person is now that he has a custom cell phone case. It even led to a new relationship when his gorgeous girlfriend noticed his custom cell phone case—and then him!" Finally, they strengthen your buying habit by rewarding you for having made such a fine choice, essentially telling you how enlightened you are and how much better your life will be for having the wisdom (or guts, or sex appeal, or some other trait) to choose their product. Ads try to generate feelings (e.g., pleasure) or other associations (e.g., scientific data confirming its superiority) that will be tied to the product that may induce you to purchase it instead of another brand (Aronson et al., 2009).

Can the commercial still be influential even if it is not focused upon? Social psychological and cognitive research suggest that messages may be absorbed

at levels outside of awareness, where a feeling of recognition can be triggered when you see the product in the store, a phenomenon already discussed known as *priming* (Lynn & Sherman, 2000; Sherman, 1988). Social psychology has also shown in many different studies that the more familiar an item is to us, the more positive regard we tend to have for it. Generally, familiarity is positive; for example, when you are in an unfamiliar location while traveling and you become hungry, you may be relieved to see a familiar hamburger restaurant. Repetition and familiarity are positive means for getting messages across. In our conscious experience, repetition is often boring, but unconscious processes seem amenable when the message isn't perceived as threatening (Aronson, 2007).

The field of advertising is obviously much more complex than this brief description may suggest, but the salient point here is that advertising uses words and images in a way that is intended to influence your buying behaviors and perhaps even your lifestyle. Can the field of hypnosis learn something from studying the dynamics of influence evident in advertising?

THE NEED FOR CLARITY AND CERTAINTY HELPS GIVE RISE TO THE THERAPEUTIC ALLIANCE

When people experience uncertainty, both social psychology and common sense have taught us that other people become very important as sources of information. The old saying, "When in Rome, do as the Romans do," reflects our reliance on other people's judgments and behaviors as models of what to do when we are uncertain about what is appropriate.

The *Candid Camera* television show, which you can view online on *YouTube* (www.youtube.com), consistently played on the themes of uncertainty and conformity by deliberately confusing people and enjoying their confusion as they would try to figure things out, desperately trying to make sense out of an absurd situation. For example, in one episode a "special" car rolls into a gas station situated at the bottom of a hill, and the driver asks for service. Upon lifting the hood of the car, the attendant is astonished to discover the vehicle has no engine. The look of utter bewilderment on the attendant's face trying to make sense of this impossibility made for great television. Typically, people's first response in the *Candid Camera* scenarios was confusion, and then they would look for outside guidance, asking someone else to help them figure out what to do. Often the person they'd turn to was an accomplice to the hoax, further complicating things for the poor victim.

The principle of increased conformity in the face of uncertainty is immediately relevant to the clinical context (Erickson, 1964a). To clients, their problems are a source of confusion and uncertainty as to what to do to solve them.

Attempts at self-correction have failed, so they then seek professional help from someone presumed to be more knowledgeable about solving the problem by virtue of having advanced clinical training. Of course, some people would rather talk to a hairdresser than a doctor, some would rather confide in a coworker than a psychologist, and still others would rather write a letter to "Dear Abby" than talk directly to anyone at all. People may invest power in someone simply because they think, rightly or wrongly, the person is more knowledgeable than they are.

The quality of the relationship between the clinician and the client has been well established as a primary basis for the therapeutic experience in general and the hypnotic experience in particular. Every therapy I am aware of emphasizes the importance of the therapeutic alliance. In the application of clinical hypnosis, the therapeutic alliance has the potential to be well defined when one develops a recognition of the factors that contribute to it. These are discussed throughout the remainder of this chapter.

CLINICIAN POWER

When individuals come in for help to deal with a distressing problem, they are making an investment in the clinician as a person of authority and, hopefully, a source of relief. Power is not typically something the clinician simply has; rather, it is acquired from the client's reaction to the clinician (Lynn & Kirsch, 2006; Spinelli, 1994). Thus, power is a capacity or potential, not a personality trait. A clinician has the potential to be influential, but every clinician learns the hard way through unsuccessful cases that influence is hardly a given in doing therapy.

Stanley Milgram and Obedience to Authority

A famous and highly controversial set of experiments on the dynamics of power was conducted by social psychologist Stanley Milgram (1974). These illustrated most dramatically how much power can be given to a person in a position of authority when seemingly average people could be led to apparently inflict harm on others in the name of compliance.

Milgram (1974) devised a basic experiment that was eventually performed in a variety of ways by varying the proximity of the participants to each other, the setting in which the experiments were performed, and so forth. The experiment involved deceiving naïve experimental subjects to believe they were involved in an experiment on learning. Directions were simultaneously given to the naïve subjects and the experimenter's accomplices—known in research as "confederates"—whom naïve subjects naturally assumed were also naïve subjects like themselves. They were told the purpose of the study was

to discover whether the use of punishment, in the form of electrical shocks, would increase a subject's ability to learn word pairs. Naïve subjects would be assigned the role of teachers and confederates the role of learners. Teachers watched as the learners were strapped into a chair and hooked up to the shock-delivering electrodes. Teachers listened as the learner disclosed having a heart condition. Then they were placed in a nearby room and positioned in front of the shock generator. The shock generator was marked with specific escalating voltage levels (e.g., 15, 30, 45 volts) as well as qualitative descriptors such as mild, moderate, severe, and extreme shock. Teachers were then instructed to deliver to learners a shock of increasing intensity with each incorrect response they gave.

Teachers were convinced the learners were getting shocked by their action of pressing the button. As the shock levels escalated ever higher as the experiment progressed, the shrieks ("Owww!") and pounding on the wall ("Let me out of here.… My heart is starting to bother me!") coming from the learner's room seemed ample evidence to the teachers that learners were truly receiving electrical shocks delivered personally by them. In reality, however, the learners were not being shocked at all. The generator and hook-up were staged. Not knowing that, though, meant teachers had to determine for themselves how far they were willing to carry the experiment. They didn't want to hurt the learners, but they had agreed to participate in the experiment and felt some sense of obligation to the experimenter. Most subjects in the teacher position were very anxious and soon became reluctant to let the experiment progress, often turning to the experimenter for guidance and permission to end the experiment. The experimenter's job was simply to say stoically, "You must go on. You have no choice but to continue. The experiment must go on."

Ultimately, about 65% of the teachers delivered the highest possible shock level, past the point on the machine labeled "Danger: Severe Shock" and past the point where the shrieking learner became eerily silent and may have been dead for all the teacher knew. This dramatic experiment is one that could not be done in identical form by today's standards of research ethics, although a recent, milder version was performed by psychologist Jerry Burger (2009) of Santa Clara University with similar results.

Milgram's (1974) experiments were based on the "obedience to authority" phenomenon evident in the Nuremberg War Crimes Trials following World War II. Many Nazis charged with exceptionally atrocious crimes claimed as a defense that "I was just following orders." Milgram wanted to know whether this was a phenomenon unique to Nazis or whether anyone might be induced to harm another person in the name of obeying an authority. The inescapable conclusion is troubling: people will go to great lengths to obey an authority they perceive as credible or if they see no choice other than to obey. If people perceive that there are no viable alternatives, they will likely follow orders even if they are destructive.

Some subjects in Milgram's (1974) experiment, when told, "You have no choice.… You must continue with the experiment," planted their arms firmly on their chests and said, "On the contrary; I have a lot of choice, and I refuse to continue." Such subjects were in the minority, however. Most people simply obeyed. The phenomenon of obedience to authority is observable in many routine contexts, including business ("Do this or you're fired"), education ("Do this or you'll be dropped from the program"), and even some intimate relationships ("Do this or I'll leave you"). Some relationships, such as that of clinician and client, are inevitably built on a markedly disproportionate balance of power. Yet not everyone is willing to use power abusively to deliberately hurt others for personal gain. Those who are, though, can make our lives considerably more difficult.

The social psychological issue of obedience to authority has generated research into the question of whether hypnosis as a phenomenon exists or whether it is merely compliance with the hypnotist's suggestions. Lynn and Sherman (2000) addressed this issue directly and clearly when they said, "Of course if hypnosis were nothing more than compliance or faking it would be of little interest to anyone. However, hypnosis is interesting to sociocognitive theorists precisely because of the 'believed in' subjective alterations it evokes" (p. 296). As Nicholas Spanos (1991), a leading hypnosis researcher on this issue concluded from the research, "… the available data also suggest that compliance, in and of itself, cannot account adequately for hypnotic behavior" (p. 336). The wary clinician should appreciate that compliance is a factor in treatment, with or without hypnosis, and the demands made on the client must therefore be chosen with care. Beyond compliance, though, hypnosis engenders a multidimensional responsiveness that is special and worthy of additional consideration in its use.

Power and the Clinician

Where does the power of a clinician or a researcher like Milgram come from? Why do some people see no option but to obey while others are able to refuse? Clearly, how much power someone has is a reflection of how much power others are willing to give. Specific to clinical contexts, the status of the clinician is one key factor and his or her perceived expertness is another. Probably the greatest capacity for power, however, comes from the social role the therapist is in; the clinician–client relationship is generally not, and usually never is, one of equals (Spinelli, 1994; Szasz, 1978). The person coming in for help must divulge personal and sensitive information to people about whom they know very little—only their professional status, and, for the more inquisitive, academic background and clinical training.

Clients are in a position of revealing their problems, inadequacies, and fears to a person who seems to be going through life successfully and relatively carefree. This is more or less true depending on the amount of self-disclosure

an individual clinician feels comfortable making. Sometimes too much self-disclosure can hurt the relationship; other times not enough can be detrimental. Regardless, the relationship is characterized by the clinician being the expert, the authority, and a client's uncertainty about how to solve a problem or an inability to detect personal choices can easily induce obedience to the authority of the clinician. Consider how extreme some forms of treatment are and even many that are just silly, yet how willingly people comply with what they are told to do by the "expert."

There are at least five different types of power: (1) coercive, derived from the ability to punish; (2) reward, derived from the ability to give benefits ranging from monetary to psychological; (3) legitimate, derived from position, including elected and selected positions; (4) expert, derived from greater knowledge in an area; and (5) referent, derived from personal characteristics, such as likeability or charisma (Aronson et al., 2009; Myers, 2009). Any or all five of these powers may be operational in almost any context to one degree or another, but they are especially evident in the therapeutic context. It may be helpful to consider the role of each form of power in the nature of the work that you do.

THE NEED FOR ACCEPTANCE

A person seeking professional help, or even just some information, is typically feeling deficient or incomplete in some way. A basic need people seem to have, which is the foundation of any society, is other people. When you combine a feeling of deficiency with a need for others, the drive for attaining acceptance begins to emerge. Acceptance is something we all want in varying degrees. Is there anyone who is truly indifferent to the reactions of others? Or anyone who genuinely likes rejection? The problem for many people isn't that they want acceptance or approval. The problem is in their seeking it from people who are either unable or unwilling to provide it. Instead of recognizing this and adjusting their expectations accordingly, they may simply double their efforts. How far are you willing to go to get the approval of others who are important to you?

One of the common fears in the mind of clients coming in for our help is, "If I open myself up to you and let you see all my fears, doubts, quirks, and imperfections, will you like me and accept me? Or will you find me weak and repulsive and reject me?" The potential for acceptance or rejection by the clinician is a risk the client takes in seeking help, and in light of all the evidence for the potential power of the therapeutic alliance it is a legitimate concern (Rogers, 1963). Recognizing and respecting clients' need for acceptance is an important factor to consider in addressing the issues of whether and how they conform to the demands of clinical intervention. How far is your client willing to go to get your approval?

Solomon Asch and Conformity

Among the most well-known studies in the literature of social psychology is the classic work of Solomon Asch on conformity (1951, 1955, 1956). His research, like Milgram's (1974), is every bit as relevant today as it was at the time it was conducted. Asch designed numerous studies to determine how others might influence us in terms of our perceptions, decisions, and attitudes. In a famous one, Asch brought in three confederates to interact with a lone naïve subject for an experiment on perception, or so the naïve subject was told. In reality, the experiment was one studying the dynamics of conformity, defined as persons changing behaviors, beliefs, or attitudes in the direction of others around them.

Asch presented to the group a series of different-sized lines, labeled lines A, B, and C, and a fourth line, X. The task of the group members seemed a simple one: they were to identify which one of lines A, B, and C was closest in size to line X. The discrimination task was an easy one since the lines were generally of distinctly different sizes. The first few rounds, by design, found all four subjects in total agreement with each other. In later rounds, though, the confederates had been given instructions to give an obviously incorrect answer. To the naïve subject, the three other people in the group were generating a seemingly incorrect answer, but they were unanimous and their previous judgments had been just fine. This unexpected wrinkle generated a great deal of uncertainty and anxiety in the naïve subjects. The typical naïve subject was so confused that when the other three subjects all agreed on an answer that seemed wrong, the subject conformed and also gave that incorrect answer. Follow-up revealed that privately subjects' perceptions hadn't actually changed; they simply conformed to the group.

Why would experimental subjects express obviously incorrect opinions as their own in the group context? Through earlier trials of total agreement within the group, a group identity, a group belongingness, and even an interdependence had formed. "Belonging" meets a basic need of people. For Asch's subjects to openly disagree and act as a nonconformist, effectively cutting themselves off from the others, was too uncomfortable a prospect for many of them to bear. People want the emotional and other intangible benefits of being enough like others to have a sense of belonging. A basic principle guiding relationships according to the literature of social psychology, and verifiable in your own experience, is that similarity is rewarding and dissimilarity is punishing.

The need for acceptance and the need to belong are also factors present in the hypnotic relationship. Avoiding confrontations with the authority, doing things to please him or her ranging from generating exaggerated therapeutic results to knitting a sweater for him or her, and conforming to his or her language style, values, and theoretical ideas are all ways this need can be

discovered within the therapy relationship. Relative to the previous discussion on power, this is how a clinician's reward power can become a considerable force in the treatment process.

Spanos, Flynn, and Gabora (1989) conducted an experiment involving hypnosis that closely paralleled Asch's conformity experiments. They gave 45 highly hypnotizable hypnotic subjects a suggestion that when they opened their eyes during hypnosis they would see a blank piece of paper. In fact, the paper shown them had a number 8 drawn on it that was large and clearly visible. A total of 15 of the 45, a full third, stated repeatedly that the paper was blank. After the hypnosis was ended, another experimenter professing neutrality about their experience questioned them about what they "really" saw. He also asked them to draw what they had seen on the piece of paper. A total of 14 of the 15 who originally claimed the paper was blank drew a number 8.

There is clearly a difference between what people may claim to experience and what they actually experience. This highlights the general importance of debriefing the client after hypnosis and of asking questions about the experience in as neutral a manner as possible. No clinical context can fully avoid what are known as the *demand characteristics* of treatment, but an aware clinician can strive to foster less compliance and more internalization on the part of the client.

EXPECTATIONS

The effects of our expectations on our experience can be profound. The power of expectation has been demonstrated in numerous places and called by many names, and virtually all models of psychotherapy emphasize the value of positive expectations in enhancing treatment results (Kirsch, 1990a; Lynn & Kirsch, 2006). Probably the most widely used term is *self-fulfilling prophecy*, describing how our behavior is unconsciously aligned with our expectations, whether good or bad, increasing the likelihood of their eventual fulfillment.

When individuals come in for help or information, typically they have an expectation of how things are going to turn out. The more emotional investment they have in that expectation, the less likely they are to experience anything that contradicts it. For example, if someone has the firm belief that a problem she is trying to solve is hopeless or unsolvable, then potential solutions people might offer to be helpful go untried. This causes the problem to remain unsolved and reaffirms the "correctness" of the view that it is unsolvable. In another example, if someone has the self-flattering idea that he is a wonderful person whom everyone sees as kind and sensitive, then someone comes along and says he did something really mean, he might dismiss it as evidence of envy, reaffirming to himself that he really is kind and sensitive. This circular kind of process is called a *calibrated cycle* in the world of systems

theory, and essentially it describes a mechanism whereby people can work very hard at staying the same, whether the effect is to maintain a good or poor self-image.

Expectations can work either for or against the attainment of desired outcomes, depending on their positive or negative quality. In the course of clinical practice, people may specifically seek you out because they have been referred to you by someone else you impressed, increasing the odds of your being able to impress that person, too. Or the individuals have a positive expectation because of your affiliation with an institution they hold in high esteem, or because of your title and status, or for any of dozens of possible reasons. Unfortunately, people can have negative expectations for equally arbitrary reasons: they don't like your gender, your age, your walk, the institution you work for, the length of time they had to wait to see you, and on and on. Addressing the issue of expectations—both yours and the client's—makes good clinical sense and helps build the therapeutic alliance (Matthews, 2001).

Some of the older hypnosis rituals aim to build positive expectations in clients that they can have, or are already having, the experience of hypnosis. Some of the subtests associated with various hypnotizability measures are included solely to convince the test subject that they have experienced some altered state. For example, when subjects are given suggestions for being unable to open their eyes, called *eye catalepsy*, and are then challenged to do so, if they pass that test they may be better convinced of being in hypnosis. This may create an expectation of benefit from hypnosis and foster greater receptivity to further suggestions of the hypnotist (Kroger, 2008).

Many of the things that are considered basic to a professional practice are intended to build positive expectations on the part of the client. Why hang your diplomas on a wall? Why print business cards with a fancy title? Why adopt a professional demeanor other than to instill confidence your client? What it takes to build positive expectations for treatment in someone varies from individual to individual. Skillfully finding out what people need to build positive expectations can be a major catalyst to getting hypnosis and the therapeutic process going in a helpful direction. My work with depressed clients in particular, people who suffer hopelessness and despair and thus have lots of negative expectations, has taught me how vitally important positive expectations are for eventual recovery. The clinical challenge is to build hopefulness out of hopelessness, and I have described some ways of doing that hypnotically elsewhere (Yapko, 1992, 2001b, 2001c, 2010). Suffice it to say here that helping clients cocreate a compelling vision of what's possible in their lives is one of the most important things that can happen in therapy.

Psychologist Irving Kirsch of the University of Hull in England is a leading researcher in the placebo effect and its relationship to therapeutic effectiveness. He has been an especially vocal proponent of a view of hypnosis suggesting that hypnosis is mostly about expectancy (Kirsch, 1990b, 1991, 1994, 1997; Lynn, Kirsch, & Hallquist, 2008). He said, "Expectancy is an essential aspect

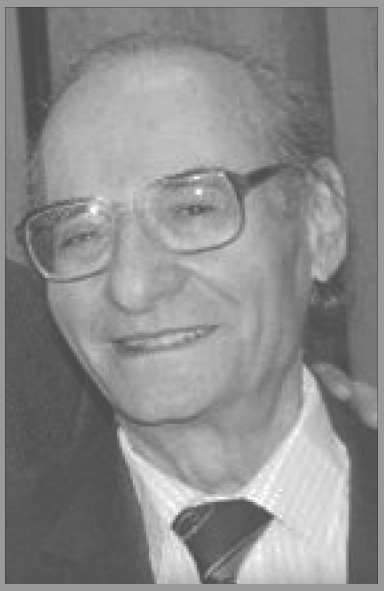


Photo by Eric Willmarth, PhD.

FRAME OF REFERENCE: THEODORE X. BARBER

Theodore Xenophon ("Ted") Barber (1927–2005) had a remarkable professional career, having been continuously involved with practicing and researching hypnosis since his early training in the 1950s as a stage hypnotist. He had first been drawn to hypnosis as a graduate student, crediting his interest to the work of Dr. A. A. Mason from a case study published in the *British Medical Journal* (1953) involving the use of hypnosis to help improve an intractable skin condition in a 16-year-old boy. It catalyzed his lifelong fascination with hypnosis, the mind–body relationship, and how suggestions translate into multidimensional responses.

By the early 1960s, research publications bearing the name T. X. Barber became both frequent and highly influential in the field. Dr. Barber posed ongoing intellectual challenges to the field of hypnosis that simply could not be ignored or trivialized. His experience as a stage hypnotist and his early experiments had made it clear to him that the notion of some vaguely defined and esoteric phenomenon called "trance" was an unnecessary and even misleading creation to explain hypnotic behavior. Instead, Dr. Barber proposed that the phenomenon of hypnosis was best understood in social terms, a concept well ahead of its time.

While others at the time were heavily invested in the notion of hypnosis as a special state of consciousness, distinct in character from other states of consciousness, Dr. Barber was conducting research which illustrated his key point: when the setting was appropriate and subjects were motivated to carry out the suggested task, their responses were not significantly different from those who had

gone through the formal, traditional rituals of hypnosis. His view of hypnosis as grounded in social phenomena grew only stronger over the course of his lifetime. In an exceptionally detailed and clear exposition of his research findings and their implications, which he published in the *American Journal of Clinical Hypnosis* in January 2000, Dr. Barber said, "We can view hypnosis in its broader context, as a social phenomenon par excellence, when we see how much of it is explained by basic principles of the social sciences which have been thoroughly documented by several generations of cultural anthropologists, sociologists, and social psychologists" (p. 232).

Dr. Barber's clinical experience was almost as varied as his research interests. He used hypnosis in the psychiatric setting with patients considered seriously disturbed; he worked hypnotically with elderly patients in a geriatric facility; and he employed hypnosis in the course of maintaining his private practice. Dr. Barber's research interests included the relationships between personality and hypnotizability, especially emphasizing the greater responsiveness of what he termed *fantasy-prone* and *amnesia-prone* individuals, hypnosis and altered states of consciousness, hypnosis and learning, hypnosis and human potential, hypnosis and healing, and hypnosis and almost everything. His interests were exceptionally varied, a reflection of his curious and brilliant intellect. This led to writings on unexpected topics, such as his observations about animal intelligence, which he addressed in a provocatively titled book *The Human Nature of Birds* (1993).

Dr. Barber contributed dozens of significant articles and book chapters on hypnosis and several classic books to the field, including *Advances in Altered States of Consciousness and Human Potentialities* (Barber, 1976), *Hypnosis, Imagination and Human Potentialities* (Barber, Spanos, & Chaves, 1974), and his landmark work, *Hypnosis: A Scientific Approach* (originally published in 1969 and reprinted in 1995).

Dr. Barber was a past president of the American Psychological Association's Division 30, now called the Society of Psychological Hypnosis, from 1971 to 1972. During his career, living and practicing in Massachusetts, he was associated with Harvard and Boston Universities, Medfield (State) Hospital, and Cushing (Geriatric) Hospital and spent the latter part of his career at the Research Institute for Interdisciplinary Science in Ashland, Massachusetts. Dr. Barber's work has been and continues to be a major influence on the most current thinking in the field of hypnosis. His imprint on the sociocognitive perspective of hypnosis is indelible.

On his early academic training: "My first undergraduate major, focusing on the great philosophers, stimulated my interest in such questions as, What is the nature and essence of reality—life and death, mind and matter, God and the universe? I then went on to a second undergraduate career concentrating on the "hard" sciences, especially the vast realms of biology. These studies led me to conclude that serious work on basic questions, especially those pertaining to mentality, consciousness, and the mind–body problem, required a deeper understanding of psychology."[2]

On his hypnosis training: "While working on the PhD in psychology, I read widely in the fascinating history of hypnotism, and I realized that hypnosis was a 'royal road' for attacking fundamental questions by scientific methods. Since academic and professional training in hypnosis was not available in those years, I studied with a stage hypnotist, and I used this training to help earn a living while in graduate school. After carrying out a series of experiments on hypnosis as part of my doctoral dissertation at American University and postdoctoral research work at Harvard, I was fortunate to receive continuous research grants from the National Institutes of Health, which enabled me to investigate hypnosis and its ramifications intensively over several decades."[2]

On effective hypnosis without a formal induction: "With or without a preceding hypnotic procedure, experimental subjects obtain relatively high scores on hypnotic susceptibility or suggestibility scales (which include tests for arm levitation, arm rigidity, analgesia, age regression, sensory hallucination, postexperimental behavior and amnesia) when they have positive attitudes toward the hypnotic or suggestive situation, positive motivations to experience hypnosis (or the suggested effects), and positive expectancies that they can experience what is suggested. These positively set subjects experience a variety of suggested effects (of the type associated with hypnosis) because they think and imagine along with the suggestions while letting go of interfering thoughts."[1]

On situational factors and hypnosis: "The extent to which subjects experience suggested effects varies with a series of situational factors. These include a variety of social factors such as social demands, roles, and expectations that obligate socialized individuals to cooperate and comply. They also include: the experimenter's or hypnotist's characteristics and skills (such as communicative abilities, creative ideas, and ability to bond with the subject); the effectiveness of the preliminary procedures or hypnotic induction procedures in guiding the subject to think and imagine with the suggestions; and the suggested ideas themselves—their depth of meaning, their creativity, and their potency for the particular subject."[1]

On exceptional fantasy-prone hypnotic subjects: "A small proportion of the experimental subjects have unusual life histories and personality characteristics that predispose them to respond easily and dramatically to hypnotic procedures and suggestions. We called one group, comprising less than 4% of our subjects, 'fantasy-prone' individuals because of their unique life histories. During childhood, each spent an incredibly large proportion of time in fantasy-based activities such as pretend play, make-believe, imagining companions, vivid daydreaming, and imaginative reliving of pleasurable sexual experiences. As adults, they secretly continue to spend much of their time fantasizing, and they typically insist they see, hear, feel, and experience what they fantasize. In hypnosis experiments they use their well-developed talent for vivid, realistic fantasy to perceive and interact in a profoundly realistic way with the suggested (hallucinatory) object, to experience vivid age regression (as they supplement their early memories with their fantasies of the suggested earlier time), to experience analgesia by deliberately fantasizing they are in a different situation (without the pain stimulus), and so on."[1]

On exceptional amnesia-prone hypnotic subjects: "The second group of exceptionally responsive subjects, which we labeled as 'amnesia-prone,' comprise about 1% of a student sample. They are characterized by the many kinds of amnesias they have experienced in their lives, typically including amnesia for virtually all of their childhood, amnesia for other scattered periods in their lives, 'lapses' or micro-amnesias in their daily lives, and amnesia for their dreams. In hypnotic situations they typically respond like deep trance subjects or somnambules, manifesting a sleep-like appearance, passivity, automatic-like responsiveness to suggestions, and convincing posthypnotic amnesia. Both their trance-like hypnotic behavior and their various amnesias are related to childhood physical, psychological, and, often, sexual abuse during which they learned to 'blank out' or enter an 'away' state and to mentally compartmentalize (or repress, dissociate, or forget) particular stimuli or events."[1]

On his varied experiences informing his views: "Our experimental research played the biggest role (in shaping my views). However, my clinical work using hypnotic procedures in therapy, in which I became well acquainted with the life experiences of a substantial number of subjects, was important in delineating the fantasy-prone and amnesia-prone subjects. Experience in stage hypnosis contributed to the conclusion that social situational variables, such as high expectancy, together with careful selection of highly responsive subjects and forceful suggestions is all that is needed to present a dramatic stage demonstration. My experience in self-hypnosis buttressed the conclusion that subjects with positive attitudes, motivations, and expectancies toward the suggested situation can experience a wide variety of suggested effects."[1]

On his most pleasant surprise in his work with hypnosis: "I was pleasantly surprised to realize that our research on producing physiological or bodily changes by suggestions (for example, successfully suggesting that localized warts would disappear) indicated a new and exciting solution to the mind–body problem. In brief, the ability to produce precise, localized changes in the body by words or suggestions indicate that nerve cells literally communicate precise messages to other cells in the body that understand and implement the suggestions carried by the meaningful messages. The indication that cells literally communicate precisely and understand the meaning of the communications, in turn, indicated that cells (and the organisms they constitute) are *physicalmental* entities or *bodyminds*. The mind–body problem disappears (or is solved) when cells and organisms are seen to be mentalized matter or embodied minds."[1]

On his personal interests: "Like most people, I enjoy my family and friends. I also enjoy the rain and the sun and the beautiful, boundless earth. My unique 'hobby' goes back to that part of my childhood that took place on a Greek island, when I learned to relate 'person to person' with the ubiquitous animals (donkeys, pigs, sheep, goats, squirrels, birds, and even ants) and to appreciate the trees and wild plants and the magic of crops rising from the earth. Thus, my unique present-day pleasure, which began in childhood and was greatly amplified and conceptualized by immersion in the literature on animal behavior, consists of literally interacting and communicating (in a 'shockingly' intimate way) with the animals in my

surroundings. A related pleasure is documenting with numerous studies that have been buried in the literature, the (scientifically tabooed) human-like intelligence of animals, which I began in a book published in the '90s and which I expand in a book I am writing now."[2]

[1] *Personal communication, October 10, 2002.*
[2] *Personal communication, November 13, 2002.*

of hypnosis, perhaps its most essential aspect" (1990, p. 143). His research has been quite compelling in demonstrating the extent to which hypnotic responses are influenced by the clients' beliefs and expectations. Thus, for the client, a good hypnotic induction is one that the client believes is a good one, and a good hypnotic experience is one that fits with what the client believes one to be (Kirsch, 1990b). Kirsch's (1994) recommendation that clinicians need to present convincing reasons for introducing hypnosis into the therapy and in ways that fit with the client's needs and beliefs is sound advice.

Kirsch's work, and that of many others, too, has its roots in the seminal research of T. X. Barber (1969), an early skeptic of the notion that hypnosis was some unique state of consciousness unlike any others. Barber was able to convincingly demonstrate that the same type and magnitude of responses that arose during hypnosis could also arise without the rituals of hypnosis just by inviting the research subject to engage in "an exercise in imagination." Barber emphasized his point in his writings in an inescapable way: he would put the word hypnosis in quotation marks, thereby calling attention to "hypnosis" as an artificial construction.

THE NEED FOR INTERNAL HARMONY: COGNITIVE DISSONANCE

Often when I flip through magazines or watch television, I am astonished by the claims made by many advertised products. Weight-loss products guarantee they are so good that you can lose weight just by looking at it (only a slight exaggeration); books for sale assure you of being able to acquire the dynamic personality that will get you into the most elite social circles; products promise to clear up your skin, grow hair in your bald spots, cure your arthritis, make you a multimillionaire, turn your house into a showcase, give you "washboard abs" in just a few weeks, and so much more.

Who buys these products on the flimsiest of promises? Who are the people in those pesky ads who gush about how this product essentially gave them a reason to go on living? This is a modern version of an old theme. Now the "medicine show" testimonials are filmed in front of an enthusiastic studio audience to show you, the skeptical buyer, that "real people" like you have purchased this

product and experienced a magical transformation as a direct result. The medicine show, 150 years ago, was a con man traveling in a covered wagon from town to town with a confederate or two sent in advance who would publicly purchase a bottle of the "Doc Marvel Health Tonic" and instantly experience relief from every known ailment. Others wanting similar relief would purchase the tonic, earning the con man a nice profit. Mysteriously, though, some of them would feel better, too.

Certainly, the person's positive expectation, a placebo effect, is at work in such instances. But there is also another factor to consider operating here: the need for internal consistency, or harmony, a core component of human personality. Social psychologist Leon Festinger (1957) is credited with elaborating the principle known as *cognitive dissonance*. He described the need people have to maintain their stable sense of themselves and the associated need to protect our view of ourselves. Part of how we do that is by striving to alleviate confusion and contradictions within ourselves, perhaps by omitting contradictory bits of information or twisting such information around until it all manages to fit within us comfortably. As social psychologists Carol Tavris and Eliot Aronson (2007) wrote in their book *Mistakes Were Made (but Not by Me)*, people can justify away the unjustifiable, from bad behavior to costly errors in judgment, preserving their self-esteem in the process.

As an example, consider the issue of locus of control in hypnosis from a different angle from that described earlier. If I want to feel in control of myself, how can I comply with your demands without feeling like I'm giving up at least some control of myself? The dilemma is, I want to be in control of myself, but I want to follow your advice so I can feel better.

Social psychological research has shown repeatedly that, like clients in psychotherapy, subjects in experiments perform far less well when they are aware of the induction of change, the goals of the situation, and the techniques of influence that are being used (Lynn & Kirsch, 2006; Lynn & Sherman, 2000). Imagine Stanley Milgram or Solomon Asch informing research subjects, "We're testing how obedient to authority you are," or, "We're testing how likely you are to conform to others' incorrect judgments." Simply put, it wouldn't have worked. So indirection and deception were used to elicit spontaneous behavior, and research subjects had to find ways within themselves to feel okay about themselves even while doing things that probably didn't feel very good.

People are generally quite adept at finding ways to make disparate pieces of experience fit together. But the larger point here concerns appreciating many clients' resistance to what they may perceive as overt manipulation by the clinician. Without a sense of control, people can feel helpless or even misperceive the clinician as "too controlling." Some may wishfully even perceive control where they have none, developing an "illusion of control." Effective use of hypnosis has to consider ways to reinforce people's sense of control yet paradoxically encourage them to step outside their comfort zone to do something differently.

People have a strong desire to feel certain, and when in an uncertain frame of mind, perhaps because of the novelty of the situation they're in, they will often turn to others to find out what to think. The more the explanation provided them fits their personal needs, the more easily the explanation is taken in at a deeper level. Thus, much of what we come to believe is less about "truth" and much more about what's personally desirable or believable.

In an illustrative piece of classic social psychological research by Schachter and Singer (1962), the point about uncertainty and turning to others to explain one's feelings is made clear. If you are chased by a bear and you experience a rapid pulse and heart rate, you can easily attribute the changes to fear regarding the bear. What if you were to experience those same physiological changes but have no clear explanation for why? Schachter and Singer's experiment involved injecting subjects either with epinephrine, a synthetic form of adrenaline causing physiological excitation, or with a placebo. Subjects were told they were receiving a vitamin supplement. Some of the subjects were told they would experience an increased heart rate as a side effect of the drug, but other subjects were not similarly informed. For subjects who were not told of the side effects of the epinephrine, what were they to conclude when their hearts started to pound in their chests and their hands began to shake? Because they did not know what to make of it, they typically incorporated within themselves the reactions of those around them.

Confederates of the researchers were introduced into the experiment, and subjects were told that this other subject, like them, was also given an injection of the vitamin supplement. The confederate had been given instructions on how to behave. In some instances, he was to act as if euphoric, while in others he was to act angry. Experimental subjects, uncertain as to the cause of their physical reactions, generally behaved in the same manner as the confederate. When subjects were certain as to the cause of their reactions, the behavior of those nearby had little or no effect on them. When they were uncertain, though, others' reactions had considerable impact on them. This research further illustrates how the ambiguity of subjects' feelings led them to conform to others' perspectives.

The need to make sense of our own reactions is an important part of developing self-awareness and being mentally healthy. But the influence of others clearly affects even the meanings we attach to our own internal experiences. What does this suggest to you about the potential vulnerabilities of our clients to the interpretations we make about the meaning of their experiences?

Here's a highly relevant implication: The experience of hypnosis is a deeply subjective, often ambiguous one that frequently leads clients to open their eyes after your hypnosis session and ask, "Was that hypnosis? Was I hypnotized?" If you say, "Gee, I'm not sure," your clients will no doubt go on to have doubts about hypnosis, you, themselves, or all of these. However, if you choose to answer directly by saying, "Yes, that was hypnosis" and then offer

them specific indicators such as, "Did you notice the changes in your breathing, the changes in your musculature, and how relaxed you felt?" then quite probably they will adopt your apparently expert perspective of the ambiguous interaction as if it were their own. The need for certainty and the need to have a perceptual frame into which the experience can be integrated may motivate clients to simply accept your explanation of the hypnotic experience.

The need for cognitive consistency sometimes shows up in funny ways that highlight peoples' quirky natures. In one now classic study, researchers investigated an experimental confederate's ability to cut in front of a long line of people waiting their turns to use a copy machine (Langer, Blank, & Chanowitz, 1978). When the confederate simply asked people in line for permission to cut in front of them with no reason given, compliance was about 60%. When the confederate wanted to cut in front of the others but offered a meaningful reason, such as, "I have an important meeting and I'm running late," the rate of compliance rose to 94%. But when the confederate asked to cut in line and also offered a reason, but a totally uninformative one, stating, "Because I have to make some copies," the rate of compliance was 93%. As Lynn and Sherman (2000, p. 306) concluded, "The presence of a request plus a reason seems to automatically trigger a compliance response." Do you have a good reason to suggest hypnosis to your client?

The need for cognitive consistency surfaces in yet another way as a need, more or less depending on individuals, to derive at least some benefit from having received professional help. When people invest money, hope, and time in something, they usually genuinely want it to work, even if "only a little." There is the need to justify the investment to themselves and perhaps others, too. This need increases with the amount of effort they have put into the treatment process. It's why many clinicians are quite forceful in their requirement that clients be a proactive and collaborative partner in the treatment process from the earliest stages of the therapy.

There can be a negative side to the role of expectation and the need for cognitive consistency. Consider the person who views herself as a hopeless case and then goes to great lengths to prove it. Some people, like the ones described earlier who go onstage to prove they cannot be "hypnotically controlled," act as if they have a need to prove their commitment to failure. It's a strange psychology, but unfortunately not a rare one, when success is determined by how much you fail. The patient who has been to every doctor in town and is inexplicably proud of his or her inability to be helped is a perfect example; the client who spends fruitless years in psychotherapy going from therapist to therapist, never really engaging with any of them, is another.

Testimonials in ads for junk products are sometimes a deceptive ploy, made up by the advertiser. Often, however, they are the true feelings of consumers who attributed great power to a useless product. After all, they watched the

whole infomercial twice, called within the time frame to get their "bonus gift," and they paid their $89.95, plus tax. And shipping and handling.

COMMUNICATION STYLE

Your style of communication is another significant factor shaping the quality of your client's suggestibility. By communication style, I refer to the manner with which you convey information and communicate possibilities to your client. There are many different styles, each having a different range and quality of impact on how receptive the client will be to the information and perspectives you present (Barber, 1991, 2000; Zeig, 2001).

If a clinician wants to get a message across to a client, he or she must consider what style of communication this person is most likely to respond to in the desired way. Should the interaction be one of rationality and reason, or would an emotional appeal perhaps work better? Should the techniques used be direct or indirect? Should the position adopted be supportive or confrontive? Would it be better to be demanding of this person or nondemanding? Will an incongruent message ("mixed message") have greater impact or a congruent one? The structures and styles of hypnotic suggestions will be dealt with in great detail later; suffice it to say here that there are many ways to package ideas, and no single style is going to be effective with everyone. Suggestibility is a general human trait, but what a specific person requires to respond well can vary dramatically across individuals.

CONCLUSION

Each of the factors of human suggestibility discussed in this chapter is important to consider in striving to understand what makes for good therapy as well as good hypnosis. There are no established rules about what makes for the most influential communication or the best hypnosis. What appeals to one person will not appeal to another. Some people appreciate and seek out professional help when distressed, while others would rather keep their problems to themselves or seek out the advice of a friendly neighbor. Some people want to be told exactly what to do in a rigid step-by-step fashion and follow such directions happily, while others fight against such explicit directions, perhaps seeing them as attempts to dominate them and thus preferring to be left alone to figure things out for themselves. Some people respond better if they have to go through rigorous demands to reach a goal (e.g., a therapist with a long waiting list is a frustration to such a new client who may perceive that therapist as better than he otherwise would have when he finally does get to see the therapist), while others won't even consider putting up with

such demands (if faced with a long waiting list they'll just go see another therapist). Some require scientific evidence for backing up almost everything you say, while others are suspicious of science and of those who promote it. Some people open up to the ideas of others when they're confused, while others close off and try to resolve the confusion within themselves, even if they do so with misinformation.

Special attention has been paid throughout this chapter to developing an appreciation for the social psychology of clinical hypnosis, examining how people's social nature has the potential to empower and disempower them. Directly and indirectly, I have addressed such fundamental topics as beliefs, expectations, attitudes, conformity, obedience, self-justification, and compliance. If you read this chapter carefully, you may have discovered that hypnosis in the clinical context might best be understood and perhaps most sensitively applied with an appreciation for your power to influence your clients. The challenge is how to do that in the most effective and respectful ways possible.

FOR DISCUSSION

1. What commercials seem to have the most impact on your buying behavior? What can you identify about them that seems to make them so influential?
2. What products or services do you feel almost entirely ignorant about (e.g., car repairs, dental work, or computer repairs)? How does ignorance about these things affect your role as a consumer?
3. Do you think Milgram's (1974) experiment on "Obedience to Authority," if replicated exactly, would have the same results today? Why or why not?
4. Describe an example or two of times when you gave in to peer group pressure. How did you feel? What penalties did you think you'd face by not conforming? Did you have control of yourself?
5. Describe an example or two in which you obeyed an authority when you thought the person was wrong in demanding what was asked of you. Why did you obey? How did you feel about the experience at the time? How do you feel about it now?
6. When you meet someone new, what impresses you? How does someone create positive expectations in you?
7. How does a therapist have each of the five powers described in this chapter? Be specific.

THINGS TO DO

1. Interview a number of physicians in regard to their ideas about the placebo effect. What is their description of the phenomenon, and how do they account for it? In what kinds of cases, if any, do they employ it?
2. List some of your most valued characteristics. How do you react when you are given feedback that contradicts your beliefs about yourself? Does your belief about yourself change? Why or why not?
3. List the feelings or situations in which you find yourself most suggestible to others in a positive sense (i.e., open, receptive). How might you say things or do things that would create these same feelings in someone else?

CHAPTER 9

RESPONSIVENESS TO HYPNOSIS

Can anyone be hypnotized? The complex issue of who can and cannot be hypnotized has been heavily researched, rationally discussed, and hotly debated by some of the most respected people in the field. It's easy to appreciate why when you start at the very beginning of the salient issues: how shall we operationally define key terms such as hypnosis, hypnotizability, suggestibility, responsiveness, depth of experience, and absorption to measure them across a sufficient number of individuals to learn anything meaningful? The semantic differences are significant and give rise to differing qualities of experience (Wagstaff, 2010). Is hypnotizability the same as suggestibility? Is hypnotic responsiveness the same as hypnotizability?

As just one example of how troublesome semantics can be, researcher André Weitzenhoffer (2002) made a distinction between *hypnosis* and *hypnotism*. He thought of hypnosis as an individual's subjective experience, an altered state independent of suggestion. He thought of hypnotism as a combination of hypnosis and suggestion, the process of inducing hypnosis. This is confusing. Can hypnosis be initiated and developed without suggestions to do so, whether from oneself as in self-hypnosis or from someone else as in hetero-hypnosis?

PEOPLE DIFFER IN THEIR HYPNOTIC CAPACITIES

The widely shared conclusion of both researchers and practitioners is that although the great majority of people can experience hypnosis to some degree, not everyone is equally responsive to hypnosis (Hilgard, 1965; H. Spiegel, 2008; Weitzenhoffer, 2000). Research subjects exposed to a variety of hypnotic inductions and suggestions show variable levels of responsiveness across conditions (Barnier & Council, 2010; Laurence, Beaulieu-Prévost & du Chéné,

2008; Spiegel & Spiegel, 1978/2004). Thus, many experts conclude that hypnotizability, generally defined in the research as an ability to respond positively to suggested experiences, is substantially more about personal factors than interpersonal or contextual ones.

Research into the capacity to experience hypnosis has examined many different personal variables including personality types (Barber, 1964, 2000; Tasso & Pérez, 2008), imaginative ability and fantasy proneness (Barnier & McConkey, 2004; Hilgard, 1980; Wilson & Barber, 1981, 1983), capacity for absorption (Brown & Oakley, 2004; Roche & McConkey, 1990; Tellegen & Atkinson, 1974), expectancy (Kirsch, 2000; Lynn & Kirsch, 2006), gender (Weitzenhoffer, 2000), age (Morgan & Hilgard, 1973), and many other factors.

What do such studies indicate about hypnotically responsive individuals? In general, they suggest that those who are more responsive to hypnosis tend to be more imaginative, have more detailed imagery, can be more deeply absorbed in experiences, process information more effortlessly and automatically, have stronger expectations of the ability to respond, and show little change in these capacities over time (Cox & Bryant, 2008; Lynn & Kirsch, 2006).

Despite the growing body of research evidence that level of hypnotizability is a variable trait across individuals but a stable trait within individuals over time (Hilgard, 1965; Piccione, Hilgard, & Zimbardo, 1989), many hypnosis experts in clinical practice prefer to focus on maximizing client responsiveness to hypnotic interventions rather than assessing hypnotizability. Instead, they operate on the premise that hypnotizability, when assessed through a standardized instrument of some sort, misses the synergistic qualities of therapeutic interaction that can enhance responsiveness to hypnosis (Geary, 2001; Gfeller & Gorassini, 2010; Gorassini, 2004). Later in this chapter I consider the notion of enhancing hypnotic responsiveness in individuals. Before doing so, let's explore the literature on intrapersonal factors affecting hypnotizability.

PERSONALITY FACTORS AND HYPNOTIZABILITY

Many researchers have explored the relationship between dimensions of personality and responsiveness to hypnosis. Test scores from personality inventories such as the Minnesota Multiphasic Personality Inventory (MMPI), Thurstone Personality Schedule, the Rorschach, the Thematic Apperception Test (TAT), the California Psychological Inventory (CPI), and many other standardized personality measures have been studied in relationship to hypnotizability as measured by standardized tests. These studies have consistently yielded similar results: no specific positive correlations exist between hypnotic responsiveness and scores on these assessment instruments (Kihlstrom, 2008; Kirsch & Council, 1992). In one study (Nordenstrom, Council, & Meier, 2002), the "Five Factor" model for describing individual differences in personality (Costa & McCrae, 1997) was studied in regard to hypnotizability. The five

factors were openness, conscientiousness, neuroticism, agreeableness, and extraversion. And, once again, no meaningful relationships were found to exist between hypnotic responsiveness and these personality characteristics.

Imaginative Ability, Fantasy Proneness, and Hypnotizability

Josephine Hilgard, in her 1980 book *Personality and Hypnosis: A Study of Imaginative Involvement*, asserted that hypnotizability was best predicted by the capacity for imaginative involvement, which she defined as the capacity for nearly total immersion in some activity to the exclusion of irrelevant competing stimuli. She clearly advocated for the perceptual process of selective attention but added in the extra element in her formulation of being selectively focused on or immersed in imaginary experience.

Theodore X. Barber (2000), in a seminal article published in the *American Journal of Clinical Hypnosis*, described the evidence for there being "at least three types of very good hypnotic subjects—the fantasy-prone, the amnesia-prone, and the positively-set" (p. 208). In his review of the evidence, he described the fantasy-prone individual as more prone to imaginative activities, daydreaming, and fantasy. Numerous studies support the relationship between fantasy proneness and hypnotic responsiveness (Barrett, 1990, 1996; Sheehan, 1979; Wilson & Barber, 1981, 1983).

People vary in their abilities and styles for both imaginative experiences and processing information. As a corollary, they differ in their capacities for imagery as well (Sheehan, 1979). Some people are quite concrete, are tied to the immediacy of their experience, are not very imaginative, and require highly detailed descriptions of experience they have already had to experience hypnosis. Others are capable of high-level abstraction and of having experiences that are not a part of their past or present experience in which imagination and fantasy can run loose in their minds and generate meaningful experiences for them. How concrete or abstract someone is in their thinking and how intensely "reality oriented" they are influences responsiveness to hypnosis simply because of the subjective nature of the hypnotic experience.

Hypnosis is not a concrete, rational type of experience, nor does it have clear, defining boundaries. There are no rockets that go off, no sirens that sound, no marching bands that come by waving banners that confirm, "This is hypnosis." The experience of hypnosis can range from being a subtle one, barely distinguishable from one's normal waking state, or it can be a very profound, distinct experience characterized by certain intense sensations and perceptions collectively identified as hypnosis. To the concrete and unimaginative individual experiencing the subtleties of a lightly hypnotic experience, the reaction is often "I wasn't hypnotized; I heard everything you said." The concrete subject should generally be spoken to in parallel concrete terms of verifiable experience. Using abstract terms such as shifts in *energy flow, distilling your essence*, or *soulful resonance* or offering New Age suggestions such as

letting your life process flow unrestricted to achieve harmony with the universe are likely to result in a cosmic failure. Some people's imaginative powers are limited, so this is one more variable to consider in formulating your approach.

Absorption, Attention, and Hypnotizability

The capacity to become absorbed in experience is yet another way for viewing the perceptual process of selective attention so clearly evident in hypnotic responsiveness. David Spiegel (2010) described it this way: Absorption "is a narrowing of the focus of attention at the expense of peripheral awareness (e.g., getting so lost in a good movie or novel that one enters the imagined world and loses awareness of the surroundings in which the story occurs)" (p. 418).

Tellegen and Atkinson (1974) described absorption as "an openness to self altering experiences" and devised an instrument called the Tellegen Absorption Scale (TAS) to measure one's quality of absorption. The 34-item TAS questionnaire is a widely used measure of absorption and has, in fact, predicted hypnotic responsiveness in research subjects to a significant degree (Council & Huff, 1990; Laurence et al., 2008; Radtke & Stam, 1991). Ted Barber (2000) suggested that many amnesia-prone subjects are also quite capable of deeper states of absorption. An interesting finding, though, is that the TAS has only a modest correlation with established hypnotizability scales. Whatever ways that might be interpreted, fostering absorption in doing hypnosis unquestionably benefits the process.

Attention is the more contemporary focus of researchers examining hypnotic capacities. As discussed in Chapter 4, the brain simultaneously relies on multiple attentional systems involving separate but interrelated functions (Raz, 2005). The Spiegels have paid considerable attention to the importance of attention and concentration in hypnosis and its essential role in shaping hypnotic responsiveness (Spiegel & Spiegel, 1978/2004). In fact, Herb Spiegel (2008) stated, "Three essential features occur in varying combinations which reflect low, mid-range or high hypnotizability when trance occurs. These features are—absorption, dissociation and suggestibility. If any one of these variables is missing, there is no hypnosis" (p. 149).

Expectancy, the "Positive Set," and Hypnotizability

The role of expectancy in shaping responsiveness to hypnosis, psychotherapy, medicine, and life experience is profound. Psychologist Irving Kirsch, a prominent sociocognitive theorist, has studied expectancy in depth, particularly as it relates to hypnotic responsiveness. He developed his "response set theory" of hypnosis in the process (Kirsch, 2000). He cited a wide variety of research supporting the notion that individuals' expectations about their ability to respond to suggestions mediates their eventual experience:

> Suggestions are statements that [are] explicitly aimed at eliciting the expectation of a change in experience and behavior. This is particularly clear with respect to direct suggestions, such as "your arm is getting lighter," "your arm is becoming numb," and "you will forget everything that has happened during this session." To accept a suggestion is to believe or expect that these events will, in fact, happen. (p. 279)

Kirsch (2000) went even further, suggesting these expectations can lead individuals to develop responses that others call a manifestation of hypnosis without the necessity of any hypnotic induction. Kirsch wrote: "There are good experimental data indicating that for the most part, hypnotic responses reflect genuine changes in experience.… However, the experiential and physiological changes produced by hypnosis do not require that the person be in a trance" (p. 278).

Ted Barber (2000) concurred and described the positively-set high responder. He characterized such individuals in this way:

> Their high hypnotic responsiveness is due primarily to their "hypnosuggestive readiness," that is, to their readiness to think, imagine, and mentally "flow with" the hypnotic induction and suggestions while "letting go" of contradictory and extraneous thoughts. Their "hypnosuggestive readiness," in turn, is due to their "positive set" which includes three dimensions: *positive attitudes* (toward the idea of hypnosis, toward the particular hypnotic situation, and toward the particular flesh-and-blood hypnotist); *positive motivation* (to experience hypnosis and the suggested effects); and *positive expectancies* (that they can experience hypnosis and what is suggested). (p. 224)

Expectancy is an especially strong factor mediating hypnotic responsiveness. I would suggest here, and have suggested in many previous writings (Yapko, 1988b, 1989a, 1993b, 2001b, 2001c, 2006a, 2010) that catalyzing positive expectations in clients represents the most important initial target of therapeutic intervention.

GENDER AND HYPNOTIZABILITY

Early studies addressing the issue of whether there are gender differences in hypnotizability yielded some data to support the belief that, in general, women may be slightly more hypnotizable than men (Hilgard, 1965). Subsequently, however, findings of any gender differences in response to hypnosis have not held up over time. Weitzenhoffer (2000) summarized his findings on the subject this way:

> (The difference) between men and women has been equivocal. That is, in general there has been a consistent small difference found favoring women over men, but never at even the 5% level of significance. This has led past researchers to reject the existence of a difference … The difference is much too small to be of practical importance or to indicate something that would be theoretically important. (p. 281)

FRAME OF REFERENCE: KAY F. THOMPSON

Kay F. Thompson (1930–1998) was an extraordinary woman and an inspiring contributor to the field of hypnosis. Dr. Thompson graduated in 1953 as the only woman in her class from her dental school, the University of Pittsburgh. Years later she was the first woman to be elected president of the Pennsylvania Dental Association in its 120-year history.

Shortly after graduating from dental school, Dr. Thompson received a brochure in the mail advertising a course in hypnosis. She attended the training out of curiosity and so began her lifelong fascination with and appreciation of clinical hypnosis. Just a few years later, in 1957, the American Society of Clinical Hypnosis (ASCH) was formed by Drs. Milton Erickson and William Kroger. Dr. Thompson promptly joined and continued her training and professional development through ASCH. She was especially close to Dr. Erickson and once remarked, "He had more influence on me than anyone but the woman who gave birth to me." Theirs was a creative and fruitful professional collaboration over the years.

Dr. Thompson soon became a widely admired teacher in ASCH and was recognized nationally and internationally for her skill, clinical acumen, sensitivity, and creativity. Eventually, she served ASCH as its president—its first ever female president. Dr. Thompson was a recipient of the highest awards offered by ASCH as well as the other major professional hypnosis society in the United States, the Society for Clinical and Experimental Hypnosis (SCEH). In 2009, her memory was honored when the International Society of Hypnosis established the Kay F. Thompson Award for Clinical Excellence in Dentistry. Generous in sharing her advanced knowledge and skills, Dr. Thompson mentored young dental students and also donated time to provide dental services at a residential facility for physically and mentally handicapped adults. She was a role model for everyone who was privileged to know her, but being the first woman in positions of power and authority in a male-dominated field allowed her to be an especially important role model for women everywhere, a fact Dr. Thompson was well aware of and took very seriously.

Dr. Thompson lectured all over the world on the intricacies of the language patterns of hypnosis, continually emphasizing the importance of using language deliberately and with an awareness that meanings are in people and not in the words themselves. She also spoke regularly about pain control and the use of hypnosis in dentistry and other physical procedures where managing pain was desirable and necessary. She was creative in her work and her use of hypnosis and was a coinventor (with Robert Pearson and Raymond LaScola) of one of the most interesting approaches to hypnosis, an overloading technique known as the *dual induction*. The dual induction is a process involving two people performing hypnosis simultaneously on a single client. Dr. Thompson's collected works are now available in a volume titled *The Art of Therapeutic Communication* (Kane & Olness, 2004).

Dr. Thompson loved elephants and collected elephant statues, elephant pictures, elephant anything. When I had the unique and life-transforming experience of working on an elephant-breeding program at the San Diego Wild Animal Park (recently renamed the San Diego Zoo Safari Park), applying some of my skill-building strategies with trainers and keepers, I got to know many elephants first-hand through daily extensive contact. (The full story of my work with the elephants is available on my website, www.yapko.com.) Dr. Thompson was mesmerized by some of the stories I shared with her of elephant behavior. It seemed a too small gift to give back to her, though, for all the times she had mesmerized me with her skills, knowledge, and humanism over the years.

On becoming a dentist: "I grew up an only child in the only professional family in the community—my father was a dentist. My father was always there to help others, and I saw it as a very caring profession. And no one told me I couldn't be a dentist! I have always had a strong work ethic and a huge sense of responsibility."[1]

On learning hypnosis: "Somehow I attracted all the frightened and phobic patients. I got a brochure on hypnosis, and went to the course looking for some 'magic' for dealing with difficult patients, and I've been involved with hypnosis ever since.… I think there are two kinds of people who work with hypnosis: the people who are truly interested in using it as a modality to help their patients or their clients, and the other people who get into it because of the need for self-aggrandizement."[1]

On meeting Erickson: "I met Erickson in October 1953. Erickson terrified me. I was fascinated but terrified by anybody who could see into your soul like that. He demonstrated that ability with every demonstration he did. I used to try to hide when it was deep trance demonstration time, but there were many times I had to 'volunteer.' I worked very closely with him until his death."[1]

On hypnotic interventions in medicine and dentistry: "Dental and medical procedures are more physiologically invasive than psychotherapy, and we have less time to help patients resolve their issues about what we are going to do with them and to them. So we have to do brief therapy if we do any therapy.… Hypnosis is

too important a tool to be limited to the pure therapeutic aspect. There are so many physiological benefits that can be obtained with it."[2]

On tailoring interventions to the individual: "I always emphasize that inductions cannot be a recipe. Each induction must be individualized. Certainly a dual induction cannot be either another's words or a script. I have seen experienced people read an induction and I don't understand why. Subjects always sense if an induction is not for them. That is something that Erickson certainly stressed, and so do I."[2]

Advice on developing skills in hypnosis: "Practice, practice, practice basic, formal induction techniques. Practice, practice, practice. Observe, observe, observe. Learn to go from formal structured techniques where you learn to observe, and slide into the utilization of metaphor.… It takes a long time—years and years of putting things into your unconscious in order to be able to rely upon it to be spontaneous.… Learn to improve, improve by learning.… You can't always know what to expect, but you can learn to handle the unexpected."[2]

[1] *Personal communication, December 8, 1988.*
[2] *Interview with Betty Alice Erickson published in* The Milton H. Erickson Foundation Newsletter*, Spring 1994.*

Despite the general lack of difference in response to standardized hypnotizability scales based on gender, there is certainly good reason to take gender into account given the substantial data showing different rates of vulnerability, differential courses, and differential responses to treatments in a variety of conditions (Linden, 1999; Waalen, 1997). One recent meta-analytic study, for example, found gender-related differences in hypnosis-based treatments for smoking and reported "a small but significant effect for male participants being more successful in quitting smoking relative to females" (Green, Lynn, & Montgomery, 2008, p. 259). In recent years, there has been a growing emphasis on acknowledging and incorporating gender differences into hypnotic procedures. Women's issues in particular have received a growing attention within the field (Hornyak, 1999; Linden, 1995, 1997, 1999). These have been catalyzed, in part, by the exceptional contributions of one of the most skilled, forceful, and important figures in the evolution of the field, Kay Thompson.

Acknowledging gender differences between men and women may well influence the quality of your communications with different clients. Language choices, the quality of your demeanor, and the emphasis you place on particular concepts or awarenesses you hope to impart can be well tailored to your client. Certainly people are more than their gender, but gender is undeniably a factor shaping subjective perceptions and so should be considered in treatment planning.

AGE AND HYPNOTIZABILITY

Does people's age influence their responsiveness to hypnosis? In a general sense, yes. In particular, the issue of age and hypnosis has revolved around differences in hypnotizability between children and adults. Research in this domain has typically examined hypnotic responsiveness in children using standardized test items adapted to children's developmental stage (Cooper & London, 1966, 1976, 1979; Kohen & Olness, 2011). Since the test items are much the same as for adults, it becomes possible to characterize hypnotic responsiveness over the course of a lifetime (Cooper & London, 1971; Rhue, 2010).

The evidence suggests that responsiveness to hypnosis emerges at a low level around age 5, rises sharply to a peak responsiveness around ages 7 to 9, begins a gradual decline in early adolescence, and stays fairly level throughout adulthood (Hilgard, 1980; Morgan & Hilgard, 1973).

Children are, in general, responsive to hypnosis but naturally require different approaches than adults do (Vandenberg, 2002). After all, the range of personal experiences is considerably more limited, and both cognitive and social abilities are less well developed. As a counterbalance, though, children also tend to have less rigid notions of reality, a greater capacity for play, including role play, and a higher level of responsiveness to authorities. Pediatric hypnosis is the topic of Chapter 24.

SELF-ESTEEM AND HYPNOTIZABILITY

Every person has self-esteem, a value we place on ourselves in terms of our perceived self-worth. Self-esteem can range from very low to very high. Self-esteem can be but is not necessarily a stable trait that remains fixed throughout one's lifetime; rather, it can go up or down with experience. Yet self-esteem is self-regulating in that it can unintentionally motivate individuals to work very hard at staying the same in important ways. For example, a person may be unhappy with a certain life situation, but at the same time she may feel fearful and uncertain about changing it and thus be immobilized. The person with a higher self-esteem, by contrast, is better able to take sensible risks, trusting himself enough to manage new situations and opportunities appropriately and thereby to continue to grow personally.

Clients' self-esteem is a significant variable in their ability to respond meaningfully to the clinician's suggestions. Self-esteem, in part, determines what individuals view as possible for themselves. The little boy who says, "Mommy, I can't do math," is not likely to be reassured by a simple, "Oh, sure you can." It creates dissonance between Mom's feedback and the boy's self-image and may lead him to make resentful, half-hearted attempts to do math or perhaps

give up trying altogether. The real skill of hypnotic communication is in knowing how to package a communication for someone in such a way as to maximize its likelihood of becoming internalized. Challenging clients' self-image by directly contradicting it is rarely a successful maneuver for changing it. Typically, they just get the feeling that the clinician really doesn't understand them and thereby devalue whatever the clinician might suggest.

MENTAL STATUS AND HYPNOTIZABILITY

Is there a relationship between hypnotizability and the development of specific clinical disorders? As psychologist Michael Nash (2008a, p. 204) pointed out, "From the beginning, those who used hypnosis to treat patients observed that alterations in mentation (perceptual, cognitive, relational and behavioral) during hypnosis seemed functionally and systematically related to alterations encountered in some forms of psychopathology." An increased responsiveness to suggestion, a greater capacity for dissociation, a deeper quality of experiential absorption, any or all of these and other factors, too, may combine to serve as a foundation for various disorders. The parallel notions of a "negative self-hypnosis" (Araoz, 1995) or a "symptomatic hypnosis" (Gilligan, 1987) have been valuable in underscoring the point made earlier that hypnosis is a neutral phenomenon, capable of generating a broad range of experiences, including therapeutic and antitherapeutic ones.

Hypnotizability has been associated with some specific syndromes (Barnier & Council, 2010). Using standardized measures of hypnotic responsiveness, higher levels of hypnotizability have been associated with phobias (Frankel & Orne, 1976), posttraumatic stress disorder (Spiegel, Hunt, & Dondershine, 1988; D. Spiegel, 2010), dissociative identity disorders (Bliss, 1986; Colletti, Lynn, & Laurence, 2010), sleep disturbances featuring nightmares (Belicki & Belicki, 1986), and eating disorders (Nash & Baker, 2010; Pettinati, Horne, & Staats, 1985), to name just a few.

When hypnotizability can be associated correlationally, not causally, with various disorders, does that mean you shouldn't do hypnosis with people suffering those disorders? The answer is unambiguous: you can do hypnosis with individuals in any category of disorder, but each person requires an individualized approach. For example, the approach you would use with someone who is depressed and ruminative would necessarily differ from the approach you'd use with someone anxious and avoidant. More to the point, though, we treat people, not diagnostic categories.

What About Psychosis and Senility?

There is no individual in treatment with whom you need to avoid either doing hypnosis or, at the least, being hypnotic. But certain disorders are considerably

more challenging to treat. Consider the effects of psychosis, for example. I had been taught that psychotic persons cannot be hypnotized. It is claimed they are unable to attend to the hypnotist's guidance due to their hallucinations, delusions, and confusion. Some psychiatrists have even said they are likely to rediagnose someone labeled psychotic if the person is found to be hypnotizable. There are others, though, who have described good clinical work involving hypnosis with psychotic patients (Baker, 1983; Brown, 1985; Murray-Jobsis, 1993; Rossi, 1980). When one teaches such disturbed patients formal, concrete relaxation procedures, makes contact with their idiosyncratic views, addresses any manipulative aspect there might be to the psychotic's behavior and removes the payoffs when possible, and metaphorically intervenes, psychotic patients may well improve.

Of course, the degree of psychosis is a variable to consider. I doubt a bipolar patient in peak manic phase, for example, can be affected by a good hypnotic suggestion or anything else verbal. The cause of the person's psychosis is an important factor as well. Drug-induced psychosis is difficult to overcome, as is psychosis associated with aging. Senility, though, depending on its degree, may not preclude hypnotic approaches. Many older patients suffering senile dementia can't remember what they were doing 5 minutes ago but can remember with remarkable clarity things that occurred 50 years ago. Regressive techniques to early experiences can have a calming, soothing effect for them. Likewise, providing basic care of these and other psychotic patients, such as routine bathing and dressing, can have very positive effects when calming and supportive suggestions are simultaneously employed.

Individuals' mental status is obviously a pervasive factor influencing whether and how they will relate to you and your suggestions. My general advice is to be willing to experiment benevolently. Sometimes you can't really know what someone is capable of until you try. I've been surprised so many times by responses I would have never predicted. As long as the focus stays on individuals' strengths and limitations rather than their diagnostic labels, the potential to help them exists. This all-important point is brought to life in a powerful way when you watch "The Case of Vicki," the terminal cancer patient you'll meet on the DVD accompanying this book. She got lost behind her labels. It may well have cost her her life.

IS HYPNOTIC RESPONSIVENESS FIXED OR CHANGEABLE?

Test–retest studies of hypnotizability using standardized scales show a high correlation, suggesting it is a relatively stable phenomenon over time. This has led many experts to consider responsiveness to hypnosis as a personality trait comparable to other personality traits (Hilgard, 1965, 1994; D. Spiegel, 2008).

In their view, it is unclear whether one is born with a high, low, or absent "hypnotic susceptibility" gene structure or whether this trait is acquired as a learned phenomenon through the socialization process. Regardless, in this view the presence or absence of the hypnotizability trait is a condition that remains relatively stable over time. In other words, if persons lack responsiveness to a formal hypnosis induction procedure, they are deemed poor subjects, or *low hypnotizable*. Further research studies on the reliability of this conclusion support it: Poor subjects seem to remain poor over time based on repeated attempts to induce hypnosis in the same person with the same or similar procedures, and good subjects seem to remain good over time. Some might argue that it is reasonable to expect the same response to the same stimulus and that this is more of a measure of the response to the test than a true measure of hypnotic capacity. Is hypnotic responsiveness a fixed capacity, or can someone's responsiveness to hypnosis be enhanced?

Enhancing Hypnotizability

A practical concern of the clinician is how to maximize the client's responsiveness to the treatment. If responsiveness is viewed as innate to the client, then there is no need to experiment with different suggestion structures and styles. Either clients have "it" or they don't. Similarly, in manualizing treatments, either the technique "works" or it doesn't. Clinicians are generally highly skeptical, though, not easily persuaded that what they do is either reduceable to a ritualized treatment or irrelevant to how the client responds. Consequently, the motivation has existed on the part of many clinicians and researchers to go beyond the data declaring hypnotizability a fixed trait in an effort to explore ways of enhancing responsiveness.

Research demands standardization. Every research subject, regardless of whether it is in research on hypnosis or research in some other area, must experience the exact same procedure for a study to be considered scientific, that is, controlled and replicable. In standardizing hypnotic inductions, the process must be the same: the timing, the hypnotist's voice dynamics, the degree of formality of the relationship between researcher and subject, the recording of responses to the procedure, the place, the lighting, and virtually every other variable must be carefully controlled. Consequently, a large number of research subjects are exposed to the same hypnosis procedure and then are given a test to determine their degree of responsiveness. The resulting statistics are published as evidence of the degree of hypnotizability of the general population of which the research population is considered a representative sample.

The standardization of techniques to promote a scientific hypnosis is a double-edged sword. On one hand, a deeper, more scientific understanding of hypnosis is desirable if we are to better understand its mechanisms and range of applications. On the other hand, summarizing clients as a low, medium, or high (or some other identifying label) reduces the ability of the clinician to

notice and respond to the uniqueness of each person. Hypnosis, like therapy, will never be only science. It will always involve art by relying on clinical judgment, creativity, and flexibility. I have gone to great lengths to make sure this book emphasizes both the art and science of hypnosis.

The important point for this section that follows what has already been outlined is that hypnotizability may not be as fixed a trait as some believe. Looking back over the sections of this chapter, you can appreciate that there's not much you can do about someone's age, but what about some of the other factors? For example, can skills in imagination and fantasy proneness be taught? What about improving self-esteem or changing someone's expectations and mental status?

Nicholas Spanos proposed a cognitive skills model that viewed hypnotic responding as a consequence of a variety of intrapersonal, interpersonal, and contextual skills such as many of those already discussed, including one's capacity for absorption and quality of expectations. Spanos (1982) argued quite convincingly that each of these factors is modifiable when people are given helpful information and training. Michael Diamond (1977, 1989b) took a similar position to Spanos and stated flatly that "hypnotizability is modifiable" (Diamond, 1977, p. 147). Jeffrey Gfeller (1993, p. 240) named four specific ways from within the cognitive skills model that hypnotizability might be enhanced, making hypnotic treatment more readily accessible to a wider range of individuals:

1. Portraying hypnosis as a cognitive experience not far removed from many everyday life phenomena
2. Discussing the concept of goal-directed fantasy or imaginative involvement and its role in hypnotic experience
3. Elaborating on the importance of absorption and suspension of reality orientation for facilitating optimal hypnotic responsiveness
4. Explaining hypnosis as an active process to be learned by the patient as a coping skill

Gfeller and Gorassini (2010) drew attention to the fact that:

> The efficacy of the strategies presented for enhancing hypnotizability, derived largely from the social-cognitive skills model of hypnosis, is supported by approximately 30 studies, conducted in 10 different laboratories, that have documented appreciable gains in hypnotic responding when persons have been provided with the facilitative information and cognitive skills training.… More than 15 studies have demonstrated that approximately 50–80% of initially low hypnotizable persons respond as highly hypnotizable following participation in a multicomponent cognitive skills training procedure. (p. 350)

Kirsch (1994) added his voice to the possibility of enhancing hypnotic responsiveness by offering specific suggestions for enhancing positive expectancy, including:

> Be permissive. Present and respect choices as therapeutic double binds, so that either choice promotes improvement. Prevent failure by beginning with easy tasks that the patient is almost certain to accomplish. Proceed gradually to more and more difficult tasks. Define tasks so that failure is impossible. Structure expectations so that even small improvements are seen as significant beginnings. Be alert to random fluctuations and capitalize on those that occur in a desired direction. Prepare patients for setbacks by labeling them in advance as inevitable, temporary, and useful learning opportunities. (p. 104)

Lynn and Sherman (2000) offered an integrative model of hypnosis that also emphasizes the malleability of the hypnotic responsiveness of the individual:

> To optimize responsiveness in clinical situations and to tailor the procedures to the unique characteristics of the individual, the integrative model implies that it is essential for the therapist to: (a) develop a positive rapport and therapeutic alliance with the patient that promotes the free-flowing quality of hypnotic experience; (b) understand the patient's motives and agenda (i.e., constellation of plans, intentions, wishes, and expectancies) in relation to experiencing hypnosis; (c) identify the personal connotations that hypnosis has for each patient, including their conflict and ambivalence about experiencing hypnosis; (d) assess the individual's stream of awareness and internal dialogue during hypnosis; (e) modify suggestions and hypnotic communications so as to minimize resistance and increase a sense of perceived control when it is lacking; (f) encourage patients to adopt lenient or liberal criteria for passing suggestions (e.g., "You don't have to imagine what I suggest as being real, even a faint image is fine"); and (g) encourage involvement in suggestions, the use of imagination, and attention to subtle alterations in experiences and responses. (pp. 303–304)

Can hypnotizability be modified? As suggested before, be willing to experiment and explore the possibilities. The general statistics may or may not apply to any given individual.

CONCLUSION

After all the research unsuccessfully attempting to relate single factors of personality, age, or whatever with hypnotizability, it has become abundantly clear that hypnotic responsiveness is a function of multiple factors operating together in some way (McConkey & Barnier, 2004). The advice offered by each of the experts quoted previously is good, sound advice. Enhancing responsiveness to therapy, delivered hypnotically or otherwise, requires a flexibility and respectfulness of clients' experience that makes it possible to bring out the best in them. The *positive psychology* in conducting clinical hypnosis sessions is to go beyond client labels, to build genuinely therapeutic relationships that foster

responsiveness, and thereby to discover the unique resources of each person that can be amplified and mobilized in the service of the therapeutic goals.

FOR DISCUSSION

1. What do you think of the statement that "anyone who can be socialized can be hypnotized?"
2. Why do some researchers and clinicians seem to conclude that if they can't hypnotize someone, then no one can?
3. What age-related factors should one take into consideration when formulating a hypnosis session? In what specific ways might an approach to a 60-year-old differ from an approach to a 20-year-old?
4. Do you believe intelligence is related to the ability to concentrate? Why or why not?
5. When should you strive to meet a client's expectations? When shouldn't you? Why do you say so? What personal and interpersonal dynamics should be taken into account in deciding whether or not to meet the client's expectations?

THINGS TO DO

1. If possible, arrange to tour a psychiatric hospital or nursing home. In observing the residents of the facility, can you determine their degree, if any, of responsiveness to hypnosis? Can you specify any approaches that might be effective with them?
2. Make a list of every rationalization you have ever used to maintain a behavior of yours that you would consciously like to change. Can you see "cognitive dissonance" at work? In what ways?
3. Spend a week or two closely watching someone you know well in a variety of situations. In which situations does this person seem open-minded and receptive? In which ones does this person seem closed-minded? What factors can you list that seem to shape this person's responsiveness?

CHAPTER 10

THE PHENOMENOLOGY OF HYPNOSIS

Phenomenology is the study of subjective experience. Hypnosis is a highly subjective experience, for it is highly personal and no two people experience it in exactly the same way. Much of the research in the field of hypnosis tends to focus on the behavior of the hypnotized person or the measurable brain changes of the hypnotized person. But watching someone's arm rise in response to a suggestion for an arm levitation or seeing evidence of greater blood flow to a particular region of the brain in response to a suggestion for an imagined experience doesn't tell you much, if anything at all, about what the person's internal experience is at such times. Simply put, what you see from the outside as you observe hypnotized individuals may or may not have much to do with what's going on inside of them. Someone can appear to be relaxed and calm, for example, yet subjectively feel distressed by the hypnotic experience (Sheehan & McConkey, 1982). Or the subjective experience can be pretty far removed from the objective circumstances: someone can feel as though transported to a past life (as in so-called past-life regressions), to a space ship (as in so-called alien abduction memories), or to some distant location (as in so-called remote viewing or out-of-the-body experiences). People can have subjective experiences they experience as "real" or believe to be "true" that may have little or nothing to do with more objective realities.

Thus, if we are to understand hypnosis, then a phenomenological level of consideration is essential: we need to know something of the hypnotized person's actual experience, and we need to know something about it with as little bias or subjective interpretation as possible. As Australian psychologist Peter Sheehan (1992) pointed out, "Adopting a phenomenological framework is a very useful means of exploring hypnotic phenomena. It enables us to look at processes, for example, in more detail than many other approaches afford,

and it reveals the diversity and richness of hypnotic experience and behavior" (p. 364). In this chapter, therefore, we explore the subjective experience of hypnosis and how research into the phenomenology of hypnosis may inform our clinical applications.

START WITH AN APPRECIATION OF EACH PERSON'S UNIQUENESS

Three foundational assumptions relevant to the topic of phenomenology guide one's practice of hypnosis. The first acknowledges the uniqueness of each person and all that implies about individuals' personal history, personality, circumstances, outlook, and responses. The second assumption is that all individuals are going to have their own idiosyncratic way of experiencing hypnosis; even when you get an expected behavioral response from people, you can't know what specific subjective associations your suggestions may have triggered in them until they are somehow communicated to you (unless you are a board-certified mind reader). The third assumption concerns the multidimensionality of hypnotic experience: whatever clients are experiencing will inevitably have cognitive, behavioral, emotional, spiritual, relational, and physical features. Which dimensions you choose to focus upon and thereby amplify will be a product of your own style of intervention.

HOW IS THE PHENOMENOLOGY OF HYPNOSIS STUDIED?

The recognition that observing hypnotic behavior is quite limited in its ability to reveal the qualities of subjective experience has prompted researchers to develop instruments for the specific purpose of getting phenomenological information. Many of the earlier instruments specifically focused on trying to understand the experience of "deep" hypnosis: what did a deeper experience feel like, and how might depth be measured? Thus, scales such as the LeCron Scale (LeCron, 1953), the North Carolina Scale (Tart, 1970), the Field Inventory of Hypnotic Depth (Field, 1965), and the Brief Stanford Scale (Hilgard & Tart, 1966) were developed and tested for their utility.

These scales proved limited in a very specific way: the depth of hypnosis did not serve as a good predictor of how successful someone would be in demonstrating suggested hypnotic behaviors. As Barnier and McConkey (2004, p. 49) stated, "These various measures of private experience recognized that hypnotic experiences may not always result in criterion-relevant behaviour of the kind

indexed by standardized scales.… Hypnotic experience is more general and more variable than response to specific suggestions, and can fluctuate in intensity from moment to moment." Furthermore, the value of the scales was limited by people's capacity for introspection and self-report (Weitzenhoffer, 2002).

People can have a partial response to a suggestion, but not enough to be evident from their behavior:

> For example, the hallucination item in the HGSHS:A (the *Harvard Group Scale of Hypnotic Susceptibility, Form A*, a common test of hypnotizability discussed later) suggests that a fly is buzzing around the person's head. To receive a positive score, the individual must overtly indicate the presence of the fly by brushing it away. If he or she hears or feels the fly but make no behavioural response, then the behavioural scale alone does not reflect the experience; a subjective scale that asks for a rating of strength of experience would capture this. (Barnier & McConkey, p. 50)

Thus, a need arose to have a better sense of both magnitude and direction of people's responses in hypnosis. To fill this need, a considerable number of scales were developed that various researchers currently use in their phenomenological research. These include two particularly worthy of mention:

1. The Experiential Analysis Technique (EAT), developed by psychologists Peter Sheehan, Kevin McConkey, and Darryl Cross (1978). Sheehan (1992) described its structure and development in substantial detail.
2. The Phenomenology of Consciousness Inventory–Hypnotic Assessment Procedure (PCI-HAP), developed by psychologist Ron Pekala (1991, 1995a, 1995b; Pekala, Kumar, Maurer, Elliott-Carter, Moon, & Mullen, 2006; Pekala & Wickramasekera, 2007). Pekala recently offered an especially succinct description of the merits of the PCI-HAP (2010).

Both the EAT and PCI-HAP strive to minimize the usual confounding factors of reporting hypnotic experience: the reliance on memory, the subjective averaging of an experience that varies from moment to moment, the tendency to report according to what the experimenter presumably wants to hear, and so on. They have been tested with a variety of research and clinical populations and can be considered effective, though imperfect, ways to elicit and describe individual responses to hypnosis. As Pekala (2002) stated when discussing the value of such tests, "This information can then be used … to implement hypnotic strategies to make therapy more individualized, and more effective" (p. 252).

What does the phenomenological research reveal about the qualities of subjective experience in hypnosis? There are many differences between hypnotized and nonhypnotized individuals, and these can be described loosely as evident in two major categories: the psychological and the physical.

PSYCHOLOGICAL CHARACTERISTICS OF HYPNOSIS

Many possible psychological shifts in subjective awareness can take place in hypnosis, including a narrowing of attention, enhanced imaginative ability, increased suggestibility, greater vividness of imagery, an array of cognitive and perceptual shifts, increased subjective conviction of beliefs, an experience of involuntariness of responses, a subjective sense of being in an altered state of awareness, a sense of being dissociated, an enhanced rapport, and increased or decreased affect, to name just a few (Cardeña, 2005; Kihlstrom, 2008; Nash, 2008b). Let's briefly consider some of these.

Expectancy

As many of the sociocognitive theorists have pointed out, clients are encouraged to expect a change in their experience and to accept those suggestions that will fulfill that expectation (Barber, 2000; Kirsch, 2000; Lynn & Kirsch, 2006; Wagstaff, 1998, 2010). Many clients actively seek out hypnosis as an intervention because they have the positive expectation that the experience of hypnosis will be powerful, dramatic, and effective (Lynn, Kirsch, & Rhue, 2010).

Selective Attention

A number of complex factors determine what works its way into individuals' field of attention, including the degree of sensory stimulation (how weak or strong the stimulus is), the novelty of the stimulus, their response tendencies (arising from a complex interplay of socialization and genetics), their motivation in the context under consideration, their mood, and the kinds and amounts of other sensory stimulation coexisting in the environment.

Focusing on a specific stimulus (usually your words or your gestures) to the near-exclusion of other ongoing stimuli is a foundation of hypnotic experience upon which the other phenomena rest. Without the focus to attend to the suggestions of the clinician, not much else that's useful is likely to happen (Oakley & Halligan, 2010; Spiegel & Spiegel, 1978/2004).

Dissociation

Ernest Hilgard's (1991) neodissociation model of hypnosis conceptualizes hypnosis as a relaxation of or decreased reliance on the executive cognitive functions. The *executive ego*, or *central control structure*, is tasked with planning and monitoring various functions of the personality, including the various cognitive subsystems subservient to the executive ego. Hilgard believed that in hypnosis, the various subsystems can become independent of or

dissociated from one another and can thus respond independently to the clinician's suggestions.

Dissociation, in effect, means that normally integrated and synergistically functioning parts of individuals are increasingly able to function autonomously. Dissociation is so critical a component of the experience that it can reasonably be said that hypnosis cannot take place without some degree of dissociation being present. In general, the greater the degree of dissociation, the deeper the person's subjective experience of hypnosis.

Increased or Decreased Affect

Recalling the earlier discussion of ideodynamic responses, and the ideoaffective response in particular, the affective component of experience comes directly into play during hypnotic experiences. Ideoaffective, emotional responses can and do arise spontaneously, that is, without any suggestion to generate any particular feeling. The emotions can, of course, range from positive (joy, pleasure) to negative (such as sadness or anxiety) in valence. The feelings can be associated to internal processes related to the therapy or can be responses to the clinician. Being observant and "tuned into" clients and being willing to explore their feelings is nearly always helpful to the therapeutic alliance and to the therapy itself.

Ernest Hilgard's "Hidden Observer"

Clients in hypnosis can have multiple awarenesses, each operating on a separate level. One of these levels is a mostly objective one that has a relatively realistic understanding of the nature of the experience, a part of the person Hilgard (1977) called the *hidden observer*. The hidden observer is separated (dissociated) from the immediacy of the suggested experiences and can maintain a degree of objectivity about the experience. Hilgard (1992) described it this way: "The 'hidden observer' was intended merely as a convenient label for the information source capable of a high level of cognitive functioning, not consciously experienced by the hypnotized person" (p. 77). This dissociative characteristic of hypnosis allows clients to attend to and respond to suggestions with a "believed-in imagination" (Sarbin, 1997) while at the same time observing themselves go through the experience more objectively. The implication of the hidden observer is that even in deeper hypnotic experiences clients typically know what they are doing and what is going on.

Martin Orne's "Trance Logic"

In a seminal contribution to the field, psychiatrist Martin T. Orne highlighted that one of the most important attributes of hypnotic experience is the ability to comfortably tolerate incongruities or inconsistencies in suggestions that in

the usual "waking" state would be disturbing (Orne, 1959). Orne offered this example of a subject's stated perceptions of transparency of another person: "This is very peculiar: I can see Joe sitting in the chair and I can see the chair through him" (p. 295). Orne termed this phenomenon *trance logic*.

In clinical practice, trance logic refers to clients' lack of need for objectifying their experience. In other words, clients can accept a suggested reality, however illogical and even impossible it may be, as if it were the only reality. For example, if I want to do an intervention hypnotically involving clients' currently inaccessible parents (who may live in a distant place or perhaps are deceased), I can suggest to clients that they see their parents and interact with them on the issues needing resolution. Trance logic allows clients to respond to their parents in the here and now as if they are really there rather than responding with an intellectual assessment such as, "How can my parents be here when they live in Europe?"

Things that don't make much logical sense can make perfect sense to the hypnotized person engaging in trance logic. This affords the clinician the opportunity to conduct clinical sessions that can be highly creative and imaginative, unfettered by a conventional sense of reality. Trance logic is a voluntary acceptance of suggestions on the part of clients, without the critical evaluation taking place that would, of course, destroy the validity or meaningfulness of provided suggestions. The opportunity to act "as if" something were real can be a gateway to deeper feelings and issues appropriate for therapeutic intervention.

Increased Responsiveness to Suggestion

The attentional and dissociative factors previously described can lead to an increased responsiveness to suggestion. Increased responsiveness is evidenced as a greater willingness in clients to be guided by the suggestions of the clinician. Furthermore, by definition, persons in hypnosis would be more responsive to experiences that they would not be outside of hypnosis.

Responsiveness is not to be confused with gullibility or noncritical acceptance of suggestions (Barber, 1969, 2000). Contrary to the mythology, the hypnotic experience in a respectful clinical or research context actually amplifies a person's range of choices, including the choice to reject a suggestion that isn't desirable or relevant. The increased responsiveness to suggestion is a choice on the part of clients to be guided by someone they trust and feel is benevolent in wanting to help. If the personal, interpersonal, and contextual dynamics are not favorable, responsiveness is nonexistent, and the result is what is classically termed a *poor response* or even *resistance*.

Fluctuations in Level of Absorption

As you have probably already discovered through your own hypnotic experiences, your experience varies from moment to moment. Sometimes you

are more engaged in what's being suggested; other times you are less so. Sometimes you are deeply absorbed in processing some image, idea, or memory; other times you are distracted by some irrelevancy or intrusion. This is natural and to be expected. Saying to clients, "Go deeper, deeper, deeper" is unlikely to lead them to do so. Rather, the inevitable fluctuations in their attentiveness are to be expected and allowed, and as the session progresses and the intervention gets progressively more focused and intense, it is likely so will clients' hypnotic experience.

Cognitive and Perceptual Flexibility

There are different cognitive styles, that is, ways of thinking about experience. This is true not only across individuals but also within individuals. You have different styles of thinking about different types of experiences. For example, some things you may approach more globally or "holistically," while other things you approach more specifically or in "detail" (Crawford & Allen, 1983; Gfeller & Gorassini, 2010). How you think naturally influences your perceptions.

As you have learned already, many of the cognitive changes associated with hypnosis surface in the arenas of memory, awareness, absorption, rationality, imaginative ability, imagery, and attention (Barber, 2000; Holroyd, 1992; Kihlstrom, 2008; D. Spiegel, 2008). These have been and continue to be heavily researched since they represent the more compelling aspects of hypnosis. Cognitive flexibility has a different connotation in a clinical context than in the research environment, however. Given how often so-called cognitive distortions (i.e., errors in information processing) are associated with various disorders (Beck, Rush, Shaw, & Emery, 1979), it becomes an even more vital application of hypnosis to be able to catalyze cognitive shifts and promote cognitive restructuring. The value of hypnosis for enhancing flexibility, whether cognitive, behavioral, perceptual, or on many other dimensions, is a primary reason for integrating hypnosis into psychotherapy in general, and cognitive-behavioral therapies in particular (Alladin, 2010; Yapko, 2001b, 2001c, 2010). The empirical evidence supports such applications (Moore & Tasso, 2008).

Cognitive styles of the hypnotized person have been studied by many researchers. Peter Sheehan (1992) in particular described different cognitive styles of response to hypnotic suggestions but concluded that "… no one style typifies the response of hypnotic subjects to suggestion, and it is interesting to note that vastly different styles of response may be adopted by equally susceptible subjects" (p. 367). He further noted, "A subject may use one or more of these styles during the same hypnotic session, and to a considerable extent the choice of style varies with the task complexity …" (p. 367). The ability to move in and out of different cognitive styles, and the different perceptual experiences associated with them, as demand dictates, and as hypnosis enhances is the essence of cognitive flexibility as described by Sheehan.

FRAME OF REFERENCE: PETER W. SHEEHAN

Peter W. Sheehan (1940–) is an Australian psychologist and a distinguished and prolific researcher in the domain of hypnosis. He is widely acknowledged for his seminal contributions toward understanding the phenomenology of hypnosis. For Dr. Sheehan, the meaning and the value of the hypnotic experience can be well understood only by exploring the different facets of individuals' subjective experience. Simply offering suggestions in hypnosis to someone and then measuring their responses is, for him, simply too narrow a lens for viewing the significance and meaning of hypnotic phenomena.

Dr. Sheehan was professor of psychology and later pro vice chancellor and deputy vice chancellor of research and postgraduate studies at the University of Queensland in Brisbane, Australia. His hypnosis research laboratory was effectively the hypnosis capital of Australia for nearly a quarter-century. More recently, he served as vice chancellor (president) of Australian Catholic University for 10 years, and he retired in 2008.

Dr. Sheehan has served as president of the Australian Psychological Society, president of the International Congress of Psychology, and president of the Academy of Social Sciences in Australia. He has received many professional and humanitarian awards, including the prestigious Order of Australia at Officer level for his lifetime of service to psychology, research, and education.

Dr. Sheehan is editor of *The Function and Nature of Imagery* (1972); coauthor with psychologist Campbell Perry of *Methodologies of Hypnosis: A Critical Appraisal of Contemporary Paradigms of Hypnosis* (1976), a book that lays the scientific foundations of his work; and coauthor with psychologist Kevin McConkey of *Hypnosis and Experience: The Exploration of Phenomena and Process* (1982) and *Hypnosis, Memory, and Behavior in Criminal Investigation* (1995). He has authored scores of articles and book chapters in leading journals and books on

such topics as imagery, susceptibility to hypnosis, suggestibility, memory and pseudomemory, and, especially, the phenomenology of hypnosis.

Dr. Sheehan's interest in hypnosis as a doctoral student led him to accept a postdoctoral position at the Institute of Experimental Psychiatry in Philadelphia conducting hypnosis research with the late Martin Orne. (See Dr. Orne's Frame of Reference in Chapter 13.). There, he learned and refined hypnosis research strategies and protocols, especially for the study of "real" versus "simulating" behavior in the hypnotic setting, and the parameters that define the essence of posthypnotic response.

This early career research gave rise to Dr. Sheehan's interest in hypnotic phenomenology, gradually leading him to the conclusion that an understanding of what persons perceive in hypnosis is vital in any effort to genuinely understand hypnotic phenomena and processes. Recognizing hypnosis as an individual, idiosyncratic phenomenon rather than as a universally shared experience seems obvious in a way, yet this inference contrasted directly with the usual aims of hypnosis research, which was at the time to identify, categorize, and group broader typologies of hypnotic experience. The pursuit of phenomenology opened up for him unexplored territories in hypnosis.

Dr. Sheehan, together with psychologist Kevin McConkey, developed the Experiential Analysis Technique as an instrument for eliciting descriptions of individual phenomenological experiences of hypnosis from hypnotic subjects. The EAT continues to be a very useful and important means of developing insight into the nature of subjective hypnotic experience.

For all his many professional accomplishments, Dr. Sheehan is a humble, understated man. He has an exceptionally keen intellect, dry wit, and a depth of character that gives rise to a gentle ease yet authoritative presence. Now officially retired, he is as busy as ever. He continues to consult with academic and government committees, especially on matters to do with the evaluation of quality research, and, among many other things, he reviews films for the Australian Catholic Office for Film and Broadcasting, indulging a passion for movies he has had for a long time that he now pursues more deeply.

On imagery as an indicator of hypnotic susceptibility: "I have never wavered from a confident position that imagery and individual differences in imagery and fantasy are very important aspects of hypnotic susceptibility. The evidence tells me that if you're a vivid imager you may or may not be susceptible to hypnosis, but if you're a poor imager, I know you're not. This approach emphasizes for me the skill components of hypnosis. Hypnosis cannot really be understood without taking into account the talents and aptitudes that the hypnotized person brings to the hypnotic context, be it clinical or experimental."[1]

On imagery vs. actual experience: "At the beginning of my doctoral studies, I was interested intensely in the question of how veridical an image is in relation to an actual experience. I also wanted to know how much belief in the reality of

things is a component of the experience of someone who images vividly. I was, and still am, intrigued by Binet and Feret's pioneering observation that in every image there is always the germ of a hallucination. I became particularly interested in the correspondence between actual perception and the experience of vivid imagery. Phrasing the research question in that way led me into an analysis of simulation. Imagery is 'as if' you are perceiving, just as an hypnotic hallucination is 'as-if' an object is really there. The development of as-if formulations of hypnosis owes much, of course, to the work of Philip Sutcliffe, Martin Orne, and Theodore Sarbin, who all explored in very different ways the social-psychological character of the hypnotic situation."

Positive motivations in hypnosis: "There is a particular motivation to please the hypnotist that exists in some hypnotic situations for very deeply susceptible people. Many researchers have theorized about this process in different ways. Some clinicians would form a link with the process of transference in the therapeutic context. In the experimental context, Ronald Shor (an experimental psychologist and early career colleague of Peter Sheehan's) expressed it in his concept of 'archaic involvement.' I think there's a link among Shor's archaic involvement, transference-type behavior in the clinical setting, and deeply susceptible hypnotic subjects' desire to please the hypnotist, whenever it occurs. I have chosen to talk about this motivation in terms of the concept of "motivated cognitive commitment" which I elaborate in some detail in my monograph published in 1971 in the *Journal of Abnormal Psychology*. I believe also that none of these notions can be seriously understood without researching a person's private experience. To understand hypnotic phenomena and processes, we need the application of a phenomenological methodology of hypnosis."

Does an accurate report of subjective experience really matter? "I remember talking to a psychiatrist about therapeutic concepts in psychoanalysis, and I asked, 'How do you know whether that really happened or not?' He said, 'It doesn't matter. If what I said fits the notions they want to talk about, I can work with that reconstruction to effect a cure.' Likewise, in peoples' subjective reports about hypnosis, it often doesn't matter what's real and what's not. Many people would find that a very controversial statement to make and would disagree with it, but when I communicate with someone about their experience in hypnosis, I'm not overly concerned about whether it's objectively real or not. It is what they are experiencing that matters the most. I recognize that there have to be exceptions to this statement. One exception, of course, is that truth is especially important in the forensic setting."

On relationship dynamics in the laboratory and in the clinic: "I think there is an enormous difference between a clinician investigating hypnosis in the clinical setting, and an experimenter investigating hypnosis in the laboratory setting. In the clinical setting, I think you can achieve responses to suggestions by virtue of the influence of the clinician. In the laboratory setting, I don't think you get as much response by virtue of the influence of the experimenter. There is an important link here to the concepts to which I referred previously—transference, archaic

involvement, and motivated cognitive commitment. I think the relationship component in the clinical setting works to make hypnosis a much more effective tool than many would think, given what seems to be happening in the experimental setting. Thus, I'm totally comfortable with the notion of profound individual differences in susceptibility in the laboratory setting and completely accepting of hypnotic outcomes for people in the clinical setting. What this indicates to me is that the relationship component in clinical settings is a very important factor in determining clients' behavioral and experiential outcomes."

On his most important research: "My most important single research program, and the most deeply satisfying to me, is described in my monograph, 'Countering Preconceptions About Hypnosis,' which was published in the *Journal of Abnormal Psychology* in 1971. That program of research took 6 years to complete, and I followed it up with a second complex program of research called "Factors Influencing Rapport in Hypnosis," which was published in 1980 in the same journal. The second program won a research award, but I have always thought it should have been the first. In 'Countering Preconceptions About Hypnosis,' I theorized on the concept of 'motivated cognitive commitment,' which I linked in the later work to the motivation of the client to please the hypnotist. I see 'motivated cognitive commitment' as an essence feature of deep hypnotic involvement. These research programs and others that I have conducted were integrated most significantly and broadly for me in the book *Hypnosis and Experience: The Exploration of Phenomena and Process* (1982)."

On memory distortion: "The phenomenology of hypnosis is very relevant to the issue of memory distortion in hypnosis and hypnotically produced witness testimonies, but there are practical circumstances where the intrusion of reality becomes paramount. What we perceive to be the case is often not what is true, and the matter of truth is all-important in the forensic setting. I hold to the hard line position that the veracity of a hypnotic memory can be established only by independent corroboration. If you place my phenomenological research within the practical context of issues in the courtroom setting, immediately I have to ask some difficult questions about veracity, confidence, and accuracy. So when someone in the courtroom says, 'I'm absolutely certain I saw that person with a knife in his hand,' I think a researcher is far more likely to query that certainty, if they don't ascribe to a phenomenological approach. In the courtroom setting, one must investigate conviction. There are too many instances where verbal reports can't be trusted. I often think of the people who have been put behind bars because of testimony that was entirely convincing but very inaccurate."

On phenomenology as the essential lens for understanding hypnosis: "The ultimate meaning of things has to be phenomenological, and I think we're not going to understand the nature of hypnosis unless we delve deeply into its phenomenology. I am disappointed in the drift of hypnosis research across to investigation of electroencephalogram (EEG) correlates, neurobiological events, and gene analyses. To me these are reductionistic ways of investigating the meaning of hypnosis. Such research can be useful, but its line of thinking has always been

very unrewarding to me, because I think that microlevels of analysis often fail to do justice to the complexities of hypnosis, and the validity of hypnotic experience. Research of that kind has the look of respectability and scientific rigor to it, but it often misses the ultimate meaning of hypnosis and bypasses its phenomenological validity."

On the next step in phenomenological research: "I used a quote in the book on the *Experiential Analysis Technique* that I published with Kevin McConkey and Darryl Cross (1978) which is very relevant to me. The book aimed to reveal a portion of the meaning of hypnosis. My advice to researchers now is, respect the experience of the hypnotized person, and you will find those other portions."

[1] *Personal communications, April 12, 2011, and April 17, 2011.*

PHYSICAL CHARACTERISTICS OF HYPNOSIS

Hypnotized individuals report many subjective shifts in their physical awareness. Often, these may be evident to the observant clinician. These shifts may include changes in a wide array of bodily sensations, general or specific changes in body image, and a disinclination to speak or move (Cardeña, 2005).

Physical characteristics of hypnosis are usually the only indicators you will have available for assessing your clients' experience unless you specifically ask for verbal or nonverbal feedback about their internal experience. Noticing the physical changes that take place in them simply provides information that can be used to further the goals of treatment. You can't use the information, though, if you don't first notice it. Thus, it is valuable to practice skills in close observation of others. Physical indicators that may be useful for you to observe include the following.

Muscular Relaxation

One can be in hypnosis without being relaxed, but the relaxation of mind and body is a general characteristic most people associate with hypnosis. Most hypnotic processes involve relaxation as a way of facilitating dissociation. Relaxation feels good to clients, alters their physical experience of themselves in an obvious way, and may even serve to convince them that they have, in fact, been hypnotized. Notice the person's level of tension carried in the body and especially the facial muscles both before and during your work for comparison. When you can see muscles relaxing, clearly an internal shift is taking place.

Muscular Twitching

As the body and mind relax, often there are spasms that are wholly involuntary and are related to the neurological changes that take place with relaxation.

Lacrimation

As individuals relax, occasionally their eyes may water. Some clinicians automatically assume they are upset and shedding a tear, but that is an unjustifiable leap to a possibly and probably erroneous conclusion. Whenever you are in doubt about what clients are experiencing, ask them for direct feedback using neutral, nonleading questions such as, "Can you describe what you are aware of right now?"

Eye Closure With Fluttering Eyelids

As individuals begin to shift their focus and experience hypnosis, their eyelids may flutter at a very fast rate and usually outside of awareness. Also, rapid eye movements under the eyelid are observable throughout much of the hypnosis session, even more so if the process involves a lot of suggestions for visualization.

Change in Breathing Rate

A change, either speeding up or slowing down, of breathing is typical. Observe clients' breathing patterns before and during the process for comparison. When you see changes in the rate and quality of their breathing, some internal shift is clearly taking place. Some people's breathing becomes shallower as they get absorbed in the process; some people's becomes deeper. Some breathe from the chest and others from the diaphragm. What's significant is the change in breathing, not necessarily the specifics of the change.

Change in Pulse Rate

A change in persons' pulse rate, either speeding up but usually slowing down, is also typical of hypnosis. When clients are sitting back, you can usually observe pretty easily the pulsing of the carotid artery in their neck. Some clinicians prefer (after asking for clients' permission) to hold clients' wrist "to be supportive" during the session and use the opportunity to take a reading of their radial pulse.

Jaw Relaxes

Often clients' lower jaw drops and seems subjectively to weigh so much that it takes conscious effort to close their mouth.

Catalepsy

The term *catalepsy* refers to an inhibition of voluntary movement, a disinclination to move or speak, that is reflective of the absorption of the hypnotic

experience. Unlike routine states of consciousness or even a sleep state in which one is in almost constant motion, clients in hypnosis make very few, if any, movements. It just takes too much effort for relaxed and focused clients. Furthermore, clients in hypnosis typically feel dissociated (i.e., detached) from their body anyway and so tend to simply forget about it.

Every once in a while, and this is especially true of children, you may experience someone who moves around a lot rather than being immobile as you might expect. In one training course, I had a student in the class nicknamed "The Thrasher." When he experienced hypnosis he liked to roll on the floor and wriggle around quite a bit. On ending the hypnosis, he described how good it felt to relax his body through movement. Interestingly, though, further questioning revealed that a lot of the movements he was making he wasn't even aware of. Even though clients' movement may seem excessive or disruptive, or interpreted as evidence that they aren't "getting into it," in fact they may still be in hypnosis. You can use the other physical indicators to support your assessment of their degree of involvement.

Bodily Sensory Shifts

The person's body awareness may change in any of a variety of ways: some people develop feelings of heaviness, as if each limb weighs a ton, while others develop feelings of lightness as if they're floating weightlessly. Some start to feel physically large, and some start to feel very small. Some people feel more closely associated to their body and become ultrasensitive to physical sensations, and others become quite detached and unaware of their body, even to the point of developing a spontaneous analgesia or anesthesia.

On occasion, individuals will report a physical discomfort associated with the hypnotic experience (Lynn, Martin, & Frauman, 1996; Pekala, Kumar, Maurer et al., 2009). It might be a slight dizziness or a mild headache. Why this happens is anybody's guess; some suggest it's the equivalent of a psychosomatic symptom—a psychologically generated purposeful symptom—and should be explored and treated as such. Others suggest that it is simply a product of being disoriented from one's usual reality-orienting environmental cues. Most of the time the resolution is as simple as encouraging clients to open their eyes, reorient, then go right back into hypnosis.

THE IMPORTANCE OF CHECKING IN WITH YOUR CLIENT

Perhaps the most important clinical implication for all that has been said about the phenomenology of hypnosis is this: if you want to know what's going on for your clients during your hypnosis session, you'll need to take active steps to find out. Whether you choose to pursue the use of formal instruments such as

the Experiential Analysis Technique or the Phenomenology of Consciousness Inventory, or some other one, or whether you prefer to simply check in and ask directly, "Can you describe what you're experiencing?" the client feedback that you get is invaluable in helping you adjust your approach accordingly.

CONCLUSION

Each of the physical characteristics previously described may be used as general indicators of hypnosis, but no one sign alone can tell you what your clients are actually experiencing internally. In a sense, the clinician is a visitor to someone else's inner world and so should be observant, cautious, and, above all, respectful.

Your assessment as to when to shift from one phase of your hypnosis session to another, for example, going from induction into therapeutic utilization of the hypnosis, will be based on how well you observe changes in clients' body and demeanor. Taking an initial baseline of level of muscular tension, breathing, and pulse rates and anything else you can notice before beginning to do hypnosis gives you the opportunity to notice changes that suggest the development of an experience that is different from the baseline. You can't always know what the content of persons' experience is, but from your guidance you can observe changes that suggest an impact. The more skilled you become in observing such changes, the more comfortable you can be in adapting to the ongoing changes in the experience of clients. Many of these changes are listed in Table 10.1, below.

Table 10.1
The Experience of Hypnosis

Experiential and selective absorption of attention
Effortless expression
Experiential, nonconceptual involvement
Willingness to experiment
Flexibility in time/space relations
Alterations of perceptions
Fluctuations in degrees of involvement
Motoric/verbal inhibition
"Trance logic"; reduction in reality testing
Symbolic processing
Time distortion
Spontaneous amnesia
Relaxation
Bodily sensory shifts

This chapter provided some insight into the internal experience of the hypnotized person. An experience as subjective as hypnosis will inevitably differ in quality from person to person. Therefore, all the general characteristics of hypnotic experience described in this chapter are likely to be present in most clients, but in varying degrees. In some cases, they may even be absent. The single most valuable source of knowledge about your clients' experience is your clients. If you want to know something about their experience, you'll just have to ask. You may not always get as truthful or as insightful a response as you'd hoped for, but individuals in hypnosis are still the best source of information.

FOR DISCUSSION

1. Why are some people so focused while others are so easily distracted? What are the advantages and disadvantages of each style?
2. Based on your own experiences of hypnosis, do you think hypnosis can be used to generate antisocial behavior in someone? Why or why not?
3. Have each person in the class describe their experience of hypnosis in as much detail as possible. What experiences seem to be common? Which ones do you recognize as being unique to that person?
4. When in the course of daily living is having a parallel awareness an asset? A liability?
5. How is suggestibility different from gullibility?

THINGS TO DO

1. Share an experience with the class of a vacation or some similarly complex experience. Which kinds of details do you tend to focus on? Why? What sort of details do class members identify as being missing or minimally present in your story? Does this indicate anything about you? What, if anything, might it indicate?
2. Do something, such as walk around the room and pick up objects of interest to you. While doing this, verbally describe your every movement. How does it feel to both participate and observe yourself doing something? Is it easy or hard to do? Why?
3. What commonly used phrases can you and your classmates think of that might generate unwanted responses in someone who responded to the phrase with literal interpretation?

CHAPTER 11

ENVIRONMENTAL AND PHYSICAL CONDITIONS FOR CONDUCTING HYPNOSIS SESSIONS

In previous chapters I have considered personal and interpersonal factors influencing hypnotic responsiveness. In this chapter, I describe environmental and physical variables that can also affect your work.

ENVIRONMENTAL VARIABLES

There was a hypnosis treatment center in San Diego years ago whose owners invested a considerable amount of money on creating the "ideal" conditions for conducting hypnosis sessions. They had large egg-shaped pods you had to crawl into, and, once enveloped by the pod, the room with thickly carpeted walls became soundless. Clients would sit in the pods and listen to prerecorded hypnosis sessions regarding their presenting problem. These special pods were equipped with an amazing array of special effects: numerous sound speakers coordinated to make sound move all around you; soft lights that flashed in random sequences to hold your visual attention; electronic gadgetry to move the arm rests slowly downward while clients heard suggestions for arm levitation; a fragrance-releasing device that might, for example, release

the smell of baby powder while clients heard suggestions for age regression or rose fragrance to accompany imagery of being in a garden; and a variety of other such clever tricks.

If you were to ask the clinicians at this center about the "best" environmental conditions for performing hypnosis, they'd likely say the hi-tech environment they created is ideal. I would disagree. (Apparently, their clients disagreed as well, for they are no longer in business.) From my perspective, forming a warm, goal-directed relationship with clients is a necessary precursor to making worthwhile therapeutic interventions. The importance of the therapeutic alliance, involving acknowledgment, acceptance, openness, trust, responsiveness, mutual respect, a shared effort, and feedback, cannot be overemphasized. Everything else, including the physical environment in which you conduct your hypnosis sessions, is secondary—secondary, yes, but not unimportant. There aren't any studies I am aware of to suggest that any one environmental condition, such as type of furniture or quality of lighting, is more likely to increase hypnotic responsiveness than another. In the real world, clinicians use hypnosis in all kinds of environments, ranging from sterile laboratories with fluorescent lighting and uncomfortable chairs apparently chosen by someone who was having a bad day, to hospital emergency rooms or clinics where noisy monitors are beeping and someone in the next bed is moaning in pain, to cavernous lecture halls where every chair seems to creak at 90 decibels, to private offices that look more like living rooms, with fireplaces, couches, soft lighting, and New Age music playing in the background. Not surprisingly, successful hypnosis has been performed in all of these environments. Certain environmental conditions are desirable for doing hypnosis, but they are clearly not essential.

A Quiet Atmosphere

Working in a relatively quiet atmosphere is especially helpful. An atmosphere free of intrusive or, even worse, obnoxious noise is less bothersome to clients, allowing them to focus more on internal experiences rather than external distractions. Realistically, however, phones ring, doors get knocked upon, people converse outside your door (if you even *have* a door), traffic zooms by, planes pass overhead, people upstairs drop heavy objects, people sneeze, pets knock over vases, kids shout, and so the list of possible distractions goes on and on. No environment is perfectly quiet and free from external noise, nor does it have to be. A key to helping clients focus internally without being unduly distracted by external events lies in your ability to tie those events into your approach. By commenting on them and framing them as "normal," perhaps suggesting something such as, "As the routine sounds of the environment drift through your awareness, you can become increasingly more focused on the possibilities I describe," clients can let the distractions recede into the background.

By not specifying which sounds you are referring to, you're offering a blanket suggestion to cover all the possibilities. Also, you are avoiding the inappropriate use of negative suggestions such as, "Don't notice the phone ringing," which will, of course, cause them to notice it.

Perhaps the best thing to do if an intrusion occurs is to use a "chaining" suggestion structure in which you can comment on the current reality of the intrusion, and then chain (i.e., associate) the desired response to the comment. For example, if the phone rings during the hypnosis session, you might comment directly by saying something such as, "Isn't it nice to know the phone can ring and since you don't have to answer it you can just relax even more deeply." Or you can comment on it indirectly by saying something such as, "As you relax, your unconscious mind can call a message up to your conscious mind about relaxing even more deeply."

Ignoring the intrusion can inadvertently lead clients to pay even more attention to it. But using the "accept and utilize" structure in which you acknowledge and make use of ongoing events, whatever they are, allows them to more readily "let it go." Intrusions are integrated as part of the experience, transforming their impact from a negative to a positive one.

Gentle Lighting

The use of soft, soothing lighting may be helpful in doing hypnosis. Lighting helps create atmosphere, and soft lighting can help facilitate comfort. I would not recommend lighting that is too dim, nor would I recommend darkness. Candlelight may be all right for some but too esoteric for others (including me).

Comfortable Furniture

As clients relax, their body tends to become heavy and immobile. Neck and backaches can easily result if clients don't receive adequate physical support. Furniture should be comfortable and, most important, support clients' head and body. Recliner chairs or chairs with footstools are quite good for this reason. Beds or couches to lie on may be too suggestive and, furthermore, are more likely to put clients to sleep, which you definitely don't want to happen during typical hypnosis sessions.

Going Inside Outside

As a final environmental consideration, Australian psychologist George Burns, in his book *Nature-Guided Therapy* (1998), made a compelling case for wanting to conduct sessions outdoors, if possible and appropriate, to make use of the natural environment as a stimulus for greater comfort. The sounds and sensations of being in a natural setting can be quite conducive to the hypnotic experience.

PHYSICAL VARIABLES

Physical conditions are also important to consider in doing hypnosis. I refer here not to clients' physical health but to the transient physical experiences that may influence their hypnotic responsiveness.

Physical Comfort

It helps if clients are physically comfortable, the body is adequately supported, clothing is not restrictive or binding, the room temperature is comfortable, they don't have to go to the bathroom, and they aren't feeling rushed either by you or life circumstances demanding immediate attention.

It is important that clients have nothing in their mouth such as gum or candy that could choke them while relaxing. Also, many people wear contact lenses, and some contact lenses are irritating if clients close their eyes even briefly while wearing them. Ask clients if they would like to remove their glasses, contact lenses, shoes, or whatever else that might diminish the experience.

Alcohol, Drugs, Medications

Alcohol and street drugs do not enhance a person's focus; rather, they diminish it and so are counterproductive to doing effective hypnotic work. Prescribed medications vary in their effects on people, so these must be evaluated on a case-by-case basis. Part of your initial assessment of clients is the quality of their attention. If they have adequate focus and can meaningfully engage with you, then hypnosis will more likely be productive. However, if their quality of focus is impaired by medications or other substances, or by their symptoms (e.g., pain, depression, and anxiety), then becoming absorbed in hypnosis will probably be more challenging. Helping someone build focus, a process of deliberate attentional training, may be an important initial goal before attempting to eventually use the hypnosis therapeutically.

Other Physical Factors to Consider

Given how many people these days are working too hard and getting too little sleep, fatigue is a common factor that can impair clients' ability to become and remain engaged in the hypnotic process. Such tired clients may simply remain unfocused or may unintentionally fall asleep as they relax. It is important that you observe your clients carefully, preventing them from falling asleep by asking for either nonverbal or verbal responses as the session progresses. It's much easier to fall asleep if you're not asked to do anything during the session but passively listen to the therapist. Once asleep, clients will be most unlikely to derive any benefit from your suggestions, contrary to the mythology about sleep learning.

The less you assume about your clients, the more objective feedback you will want to seek about their condition. You cannot assume they have normal hearing, normal physiology, no contact lenses, no gum in the mouth, no use of street drugs or alcohol on therapy days, and so forth. It takes only moments to ask, and your sensitivity to such issues can save you and your clients a lot of frustration later. The key here, as in the environmental conditions, is to use the spontaneous events that arise. If clients cough, don't fret. Accept and utilize it by saying something such as, "As you clear your throat, your throat can relax … and then you can relax even more deeply." Or you can offer some statement that is less direct, such as, "It's good to clear the way … to be able to take in new ideas."

Following the "suggestion chaining" format of tying "what is" to "what can be" is the key to coping with environments that aren't perfect and clients who sneeze, cough, laugh, frown, jiggle, or cry in the middle of your hypnotic process. It helps to get comfortable in tying spontaneous occurrences into your work. No environment or client is completely controllable, so you just have to "go with the flow" and use the temporary distraction as a means for furthering the goals of the session. Ultimately, skilled communication is the primary factor in successful hypnosis, not the chair you use.

CONCLUSION

It's a matter of personal and professional judgment, as it must be, as to what is considered a good balance of comfort and professionalism when creating a context for conducting hypnosis sessions. Sometimes the decision is made for you because the institution you work for is what it is in terms of atmosphere. Other times you have the ability to choose how to set the stage for your work. As long as the context seems to support the work you do from clients' perspective, you can move forward with applying the communication and clinical skills necessary for designing and delivering effective treatments.

FOR DISCUSSION

1. What kind of physical environment for doing hypnosis would you create if cost were no barrier?
2. What is your opinion of the "computerized hypnosis" approach described in this chapter? Why do you feel that way?
3. How might ignoring an intrusion cause clients to pay even more attention to it?
4. Do you think suggestions from a digital source (DVD, CD, MP3) can be as effective as those delivered live? Why or why not?

THINGS TO DO

1. Make a list of the most common intrusions you are likely to encounter while doing hypnosis in the place where you work. Generate five suggestions for each intrusion that can help you make positive use of it whenever it arises during your hypnosis process.
2. Visit a variety of offices of clinicians who use hypnosis, noticing the type and physical arrangement of their furniture. What seems most practical to you?
3. Vary the arrangement of seats from class practice session to practice session, ranging from very close together to far apart, from frontal to side by side. Do you notice any differences in people's level of responsiveness to you? How do you account for whatever differences you may observe?

CHAPTER 12

HYPNOSIS AND POSITIVE PSYCHOLOGY

If you can walk, you can dance. If you can talk, you can sing.

—A Zimbabwe tribal saying

It was 1972, and John Lennon and Yoko Ono were guests on *The Mike Douglas Show*, a popular entertainment program at the time. John good-naturedly described his first meeting with Yoko Ono, then an avant-garde artist who had an exhibition of her work taking place at a London art gallery. The gallery was owned by a friend who invited John to see the exhibition privately before it opened to the public. One of Yoko's artworks on display required climbing a white stepladder to look into a magnifying glass to see a small word written on a framed canvas on the gallery ceiling. When John climbed up and looked through the magnifying glass, he clearly saw the word: Yes. John said that seeing the word yes captured him; he liked "the positive message" and said it "felt like a personal yes to me." Had the word been no, he said, he believes he wouldn't have been further interested in either Ono or her art. (The interview can be seen on YouTube, www.youtube.com: search *The Mike Douglas Show*, John Lennon and Yoko Ono, February 14, 1972, part 2). This is a unique testimonial to the power of yes.

Whether you generally and reflexively orient to yes or no, the positive or the negative, and what's right or what's wrong across your life experiences speaks volumes about your quality of life. Given how powerful a force your orientation toward the inevitable ups and downs of life is on many different quality-of-life measures, it's surprising that only relatively recently has there

emerged a psychological and social science concerned with the study of a "yes" orientation toward life. That science is known as positive psychology.

Since its formal inception in a presidential address by psychologist Martin E. P. Seligman on August 21, 1999, at the annual convention of the American Psychological Association, and its subsequent elaboration in a special issue of the *American Psychologist* (Seligman & Csikszentmihalyi, 2000), positive psychology has quickly grown in popularity, depth, and breadth of subject matter and empirical support. Scores of empirical studies, books, and articles have been published on the subject. It has garnered many millions of dollars in research grants, and its first international conference, held in summer 2009, drew more than 1,500 people from more than 50 countries. Many other such conferences have been held since. Courses in positive psychology are now offered at many leading universities and are among the most popular courses offered. Its aims and methods have been adopted by many different organizations, both private and public, including the U.S. military (Seligman, 2011).

In this chapter, I will describe some of the key aspects of positive psychology and how hypnosis can be used to amplify their merits. Hypnosis as a vehicle of psychological intervention offers a practical means for actualizing the aims of positive psychology in ways I will articulate.

WHAT IS POSITIVE PSYCHOLOGY?

Positive psychology has been defined as the "scientific study of the strengths and virtues that enable individuals and communities to thrive" (2007, Positive Psychology Center, University of Pennsylvania website; www.ppc.sas.upenn.edu). It has been further described as an "umbrella term for the study of positive emotions, positive character traits, and enabling institutions" (Seligman, Steen, Park, & Peterson, 2005, p. 410).

Considered its primary architect and spearhead, Martin Seligman described the moment that positive psychology became more than an intellectual curiosity. It was in an interaction with his 5-year-old daughter, Nikki, while they were weeding the garden together. A self-acknowledged goal-oriented grouch, a "walking nimbus cloud in a household radiant with sunshine" (Seligman, 2002, p. 28), Seligman was singularly focused on the goal of weeding and confessed his irritation with Nikki's distracting behavior of playfully throwing weeds into the air and dancing and singing. Seligman wrote:

> Since she was distracting me, I yelled at her, and she walked away. Within a few minutes she was back, saying, "Daddy, I want to talk to you."
>
> "Yes, Nikki?"
>
> "Daddy, do you remember before my fifth birthday? From when I was three until when I was five, I was a whiner. I whined every day. On my fifth birthday, I decided I wasn't going to whine anymore.

> That was the hardest thing I've ever done. And if I can stop whining, you can stop being such a grouch."
>
> This was an epiphany for me … In that moment, I resolved to change. (p. 28)

Seligman realized in that moment that Nikki was right—he was a grouch but didn't want to be one any longer. Given his considerable successes in so many aspects of his life, what was there to be grouchy about? The challenge to himself was clear: Could he become authentically happy by shifting his focus to what's right rather than focusing on overcoming what was wrong?

He also realized in that moment that the goal in parenting Nikki effectively wasn't merely about identifying and correcting her flaws: "Raising children, I knew now, was far more than just fixing what was wrong with them. It was about identifying and amplifying their strengths and virtues …" (Seligman, 2002, p. 28).

What Seligman, along with like-minded colleagues, soon discovered, however, was that the idea of helping people become more positive had only occasionally been considered before and more as philosophical musings than a scientifically informed process. As they perused the literature, they came across the pioneering works of Carl Rogers (1951) on how to be more "fully human," Abraham Maslow (1962) on how to become "self-actualized," and the works of many others as well, including Erik Erikson (1963), and George Vaillant (1977). Their work was valuable, of course, but went only so far in the absence of a scientific grounding. It highlighted the need for an empirically supported means of not only treating mental illness but also fostering people's happiness. Only a disciplined science of studying the best parts of people could provide enduring perspectives and methods that could truly make a difference. It is to Seligman's great credit that he had the vision and means to make positive psychology a growing force in the field of psychology and other fields concerned with human performance and wellness.

Suggesting a Shift in Focus Away From the Pathological

Trying to find serious literature on human strengths and virtues was a challenge for positive psychology at its start. There just wasn't that much of it. Most of the literature in psychology dealt with human weaknesses and vulnerabilities. There was far more literature on depression than happiness, for example. Worse, though, was discovering how often the clinical literature regarded positive aspects of human experience to be the product of psychological defenses, compensations for underlying issues, such as being generous out of a presumed underlying guilt rather than a sincere desire to help others. A smile was a way to hide presumed unconscious hostility. Positive traits were often simply considered ways of covering up the "real" negatives. Seligman (2000) posed the salient questions in the following:

> How has it happened that the social sciences have come to view the human virtues—courage, altruism, honesty, faith, duty, responsibility, good cheer, perseverance—as derivative, as illusions, and as defensive, while the human weaknesses—greed, anxiety, lust, selfishness, fear, anger, depression—are viewed as authentic? Why aren't human strengths and human weaknesses symmetrical in their authenticity? (p. 416)

As a direct result of jolting the profession out of its reflex to pathologize people, the focus shifted from the negative to the positive when Seligman (2000) articulated the goals of positive psychology:

- Articulate a vision of "the good life" that is empirically sound while being understandable and attractive to people
- Show what actions lead to well-being
- Show what actions lead to positive individuals
- Show what actions lead to thriving communities
- Document what kinds of families result in children who flourish
- Document what kinds of work settings support greatest satisfaction among workers
- Document what kinds of social and political policies result in strong civic engagement
- In short, identify how peoples' lives can be most worth living

Psychologist Chris Peterson (2006) is a key figure in the positive psychology field. He described in greater detail the three primary domains of research:

> We can parse the field into three related topics: (a) positive subjective experiences (happiness, pleasure, gratification, fulfillment), (b) positive individual traits (strengths of character, talents, interests, values), and (c) positive institutions (families, schools, businesses, communities, societies). (p. 20)

For psychotherapists, all three topics tend to be of great interest. However, as Park and Peterson (2006) pointed out, "Among the pillars of positive psychology, character may occupy the most central role.… Positive experiences like pleasure and flow come and go, but are enabled by good character. Positive institutions … are only positive in the first place when comprised of people with good character" (p. 29). But what do we really know about character, especially character strengths and virtues, and how to encourage them?

Peterson and Seligman were involved in a project the goal of which was to attempt "to define, describe, classify and measure strengths of character—positive traits like kindness, love, forgiveness, hope, and humor" (Peterson, 2006, p. 29). The result is an impressive volume called *Character Strengths and Virtues: A Handbook and Classification* (Peterson & Seligman, 2004). In stark contrast to the psychiatric manuals that define and describe pathologies, arguably a necessary classification system for professionals working in the mental

health arena, *Character Strengths and Virtues* offers well-researched, cross-nationally, cross-culturally relevant data and insight as to what have come to be called individual "signature strengths." These are the various strengths of character that differ in type and magnitude across individuals. They include: (1) wisdom and knowledge (encompassing creativity, curiosity, open-mindedness, a love of learning, and perspective); (2) courage (encompassing authenticity, bravery, persistence, and a zest for life); (3) humanity (encompassing kindness, love, and social intelligence); (4) justice (encompassing fairness, leadership, and teamwork); (5) temperance (encompassing forgiveness, modesty, prudence, and self-regulation); and (6) transcendence (encompassing an appreciation of beauty and excellence, gratitude, hope, humor, and spirituality) (Park & Peterson, 2006). As Park and Peterson are careful to point out, "focusing on strengths does not mean denying or ignoring weaknesses in any way.… However, identifying strengths … and strengthening them may be a good way to (enhance) any intervention" (p. 31).

Therapy is an obvious context for helping people discover, strengthen, and effectively utilize their signature strengths. In psychotherapy, people who suffer seek the help of a professional who is entrusted to alleviate that suffering. The challenge is a formidable one under the best of conditions. For the clinician who recognizes the considerable responsibility that goes along with being an agent of change, it has become ever clearer how his or her perspectives—an orientation toward yes or no, weakness or strength, positive or negative—will shape the clinical interaction. Is the goal of treatment to reduce pathology or to expand wellness? This is not merely a semantic issue. Rather, as my Australian friend and colleague George W. Burns captured so skillfully in his excellent book *Happiness, Healing, Enhancement: Your Casebook for Applying Positive Psychology in Therapy* (2010), it defines every phase of clinical interaction, from what questions to ask in a clinical interview to how to structure interventions to knowing when to terminate treatment.

Optimism, Pessimism, and Quality of Life

It has been said that there are two kinds of mystics in the world—the opti-mystics and the pessi-mystics. In the past, it was considered a simple matter of personal outlook and philosophy whether someone saw the glass of life as half-empty or half-full. It didn't really seem to be of serious consequence. That has changed markedly, though, as the scientific evidence has accumulated quickly and convincingly that your relative degree of optimism or pessimism exerts a profound influence on a variety of areas of your life, including your physical health and longevity, mood, productivity on the job, social attractiveness, and resiliency in the face of adversity. There is substantial empirical evidence attesting to the merits of optimism; optimists have fewer serious health problems, and when they do they have fewer doctor visits, fewer complications, and shorter hospital stays.

Optimists tend to live longer. Optimists tend to have fewer mood problems. They also tend to be more productive on the job and better liked by other people. Optimists tend to bounce back from adversities more quickly and completely, too.

These are some compelling reasons to want to catalyze optimism and encourage more of the happiness that goes with it. What are the general traits of happy people? Social psychologist David G. Myers (2000) has been studying happiness for at least 2 decades and has some insights in response to that most important question:

> Across many studies, four positive traits have marked happy lives.… First, happy people like themselves.… Second, happy people tend to be *extroverted*.… Third, happy people typically feel *personal control*.… Fourth, happy people are commonly *optimistic*. (p. 330, italics in original)

Many clinicians are concerned, then, with how to catalyze these traits in their clients. Positive psychologists have developed a variety of strategies to help in this regard. Several good examples of these will be described in a later section.

Is Happiness a Good Thing?

Despite the fact that the personal and interpersonal benefits to happiness are measurable and the insights into what fosters happiness are evolving, not all are unanimous in their support of research on the subject. The merits of happiness have been discussed on abstract, philosophical levels ("Do I have a right to be happy when other people are suffering?"), and even challenged as a trivial pursuit by some. Positive psychology has provoked some openly hostile responses in some psychologists who think the profession should be paying attention to more serious issues. One therapist wrote the following letter in response to a special issue of *Family Therapy Magazine* (November–December 2006) on the subject of happiness:

> I cannot believe the shallowness, cultural pandering, and global insensitivity.… While we discuss "happiness," the rest of the world faces war, famine, rape, homelessness, and natural disasters.… In our country, millions look for healthcare, affordable housing, enough to eat, and a job while we discuss upper-middle-class pampering (Phillips, 2007, p. 3).

This criticism is not entirely without merit. However, it also misses the larger point: positive psychology strives to better understand and then develop the very qualities in people and the institutions that people form that would reduce and perhaps even eliminate such problems. The goal isn't to have happy but morally bankrupt people. The goal is to bring out the best in people on a variety of levels. Other critics have voiced their concerns as well (Lazarus,

2003; Kristjánsson, 2010). Beyond questioning the relative value of striving to encourage happiness, they have also pointed out some of the internal conflicts and contradictions within the positive psychology movement. What should we make of these criticisms?

The field of positive psychology is very young and still in the earliest stages of development. Of course there will be inconsistencies in methods and findings and even contradictory views within the field. These won't be going away anytime soon. The same could be said for any social science discipline and specific subject, even those that have been around far longer. The deep divisions in the domain of psychotherapy bear witness to that fact.

This section is included for a critically important reason: all psychotherapists reading these words must consider carefully how they will use the skills of hypnosis learned here. Clients in therapy generally don't care about the philosophical merits of happiness; for them, it's far more personal. They're suffering and they want to feel better. What is the better path for a clinician to follow in guiding someone's journey to greater wellness? The answer, as it must be, is up to each individual clinician based on his or her clinical training, philosophy, and outlook. These are all filtered through whether your general response to life leans more or less in the direction of yes or no.

Milton Erickson (1954) captured the essence of the dilemma when he commented on the value of learning in the context of psychotherapy as an experiential means of amplifying what's right with people: "To assume that the original maladjustment must necessarily come forth again in some disturbing form is to assume that good learnings have neither intrinsic weight nor enduring qualities, and that the only persisting forces in life are the errors" (p. 127). Erickson's comment highlights the merits of therapies designed to provide positive experiences, positive perspectives, and positive skills.

These positives must be realistic, though. Can people be unrealistically optimistic? Yes. They can easily delude themselves by thinking, "I can smoke and it won't hurt me," "I can drink and still drive just fine," or, "My kids will be fine no matter what I do." Some of the most destructive decisions, whether by individuals or nations, have been made while riding a wave of optimism that had too little to do with reality. Thus, the goal is not simply be more optimistic. Rather, the goal is to be realistic. Helping people to view things more realistically and to make better decisions as a result not only has huge treatment value but prevention value as well.

Therapy Based on a Positive Psychology

Based on Myers' (2000) well-supported findings on happy people and those of the broad array of studies examining the multidimensional merits of optimism, some of the key targets of good psychotherapy seem evident. Psychotherapy should (1) encourage self-respect and self-acceptance, (2) encourage people to

build and maintain healthy relationships with others, (3) empower people to make and implement choices skillfully, and (4) encourage a positive orientation to the future. To address the fundamental question, can positive psychology make people lastingly happier?, researchers designed happiness exercises that were delivered via the Internet (Seligman et al., 2005). Participants were visitors to the website created for Seligman's (2002) book *Authentic Happiness,* who also clicked on the link called "Happiness Exercises." Participants were chosen for their expressed desire to be happier, consistent with the goal of the interventions. Participants were to do the exercise for at least 1 week and were followed for 6 months, during which time they completed measures of both depression and happiness.

Of the five happiness exercises and one placebo control exercise offered, two of the happiness exercises successfully increased happiness and decreased depressive symptoms for 6 months. A third happiness exercise generated large positive changes, but for only a month. The remaining exercises, including the placebo, created positive but transient effects on happiness and depressive symptoms. As Seligman et al. (2005) wrote, "Not surprisingly, the degree to which participants actively continued their assigned exercise on their own and beyond the prescribed one-week period mediated the long-term benefits" (p. 416).

The two exercises that generated the most enduring (6 months) effects were as follows:

Three good things in life: "In this exercise participants were asked to write down three things that went well each day and their causes every night for one week …" (Seligman et al., 2005, p. 416).

Using signature strengths in a new way: "Participants were asked to take our inventory of character strengths online … to receive individualized feedback about their top five ('signature') strengths. They were then asked to use one of these strengths in a new and different way every day for one week …" (Seligman et al., 2005, p. 416).

The exercise that generated positive changes of a large magnitude, but only for one month, was as follows:

Gratitude visit: "Participants were given one week to write and then deliver a letter of gratitude in person to someone who had been especially kind to them but had never been properly thanked" (Seligman et al., 2005, p. 416).

The two other exercises (identifying signature strengths without trying to use them in new ways and writing out a life episode in which they were at their best with the direction to simply reflect on the strengths in the story) and the placebo exercise (writing about early memories every night for a week) produced little or no benefit.

The exercises that produced lasting results have been further elaborated, honed, and tested. These, and many others, have been well described in psychologist Sonja Lyubomirsky's (2008) excellent book *The How of Happiness: A New Approach to Getting the Life You Want*. Her optimism, evident in the title, is not unfounded. As Seligman et al. (2005) pointed out from their research of the effects of the happiness exercises, "Effect sizes were 'moderate' or larger, which is at odds with the widespread belief that the pursuit of happiness is futile because of inevitable adaptation or an immutable hedonic set point" (p. 419). The message is clear and reinforces what has been said already many times in many ways in this volume: experience changes people, and carefully constructed experiences can help change people epigenetically, neurologically, emotionally, behaviorally, cognitively, socially, and spiritually.

What Role for Hypnosis in Advancing Positive Psychology in Therapy?

As has been discussed in a variety of places throughout this volume, whether one calls them "happiness exercises" or "therapeutic strategies," the specific behaviors prescribed by the therapist are only partially responsible for any derived benefits. It is always necessary to bear in mind that as good as any technique might be, unless the context in which it is applied fully supports the use of that technique, the technique will have limited value at best. At worst, the technique can do worse than simply fall flat: it can actually set back clients' progress. Techniques are delivered in the context of a therapeutic relationship and encompass many variables: trust, timing, delivery, expectation, level of demand, and many others as well.

In a way, this makes the results of the happiness exercises even more compelling: they were delivered anonymously over the Internet to individuals with whom the researchers did not have any personal relationship. The therapeutic alliance, deemed so critically important by virtually all therapists, may have had form in this research but no real substance. Thus, what is highlighted in this research and other similar research is the all-important value of structured experiential learning in catalyzing therapeutic results.

The value of experiential learning is one of the most, if not the most, compelling reasons we conduct hypnosis sessions with our clients. Simply telling them, "Stop that!" or "Do this!" isn't enough. How can we create a context—a therapeutic environment—with all its associated complex variables that will support the strategies we employ? This is the role of hypnosis in supporting interventions rooted in any modality, whether in positive psychology, cognitive-behavioral therapy, or some other approach.

Tilling the Soil and Then Hypnotically Planting the Seeds of Positivism

The happiness exercises were delivered without benefit of first focusing the clients, building up their positive expectancy, building a response set to

gradually draw them into the desired frame of mind, then absorbing them in specific new images and ideas they could use to associate to an individual positive psychology. Participants weren't encouraged to be willing to experiment with new behaviors with the promise of benefit, nor were they encouraged to stay with the exercise even when doubts arose or results weren't immediately evident. And there was no assurance that results would continue to accrue spontaneously as the new reflexive perspectives became integrated. These are all things someone doing hypnosis within a positive psychology framework would likely do to make the happiness exercise become more than an exercise. The exercise becomes the basis for developing new resources that can, when skillfully nurtured, become a stable and reliable part of clients' ongoing lifestyle.

Three Good Things in Life The principle that "what you focus on you amplify" drives the therapeutic merits of this exercise. When people focus on what's imperfect or wrong, it naturally catalyzes many negative reactions: anger, frustration, resentment, self-criticism, and so forth. Hypnosis involves shifting both the direction and intensity of focus. By structuring an exercise such as this one that deliberately shifts attention to at least some things that are right, the potential to lessen negative feelings while becoming of aware of what's good in life and amplifying the positive feelings associated with them provides a great opportunity for feeling better. It can provide a powerful reframing of the rigid belief that "life is all bad."

Before delivering the exercise, though, how valuable might it be to conduct a hypnosis session that encourages the recognition that perception is malleable? That what we focus on influences our mood states and that shifts in what we notice can be self-regulated, self-enhancing, and self-perpetuating? Absorbing the person hypnotically and suggesting a growing and enduring awareness for "wonderful things that may have been there all along that you just never noticed before" can pave for way for a more reflexive focus on the "good things in life." The exercise then builds further on the expanding awareness that every day there are good things in life to notice if only you would make a point of doing so. Further hypnosis sessions continue to consolidate the gains and stabilize them over time.

Using Signature Strengths in a New Way It is a repetitive theme of therapy that clients are feeling victimized, too personally disempowered to even perceive, much less take, effective action in the direction of problem solving. Telling people, "You're a good person" or "You're capable of so much more" isn't going to have much of an effect on people. In fact, the related exercise of simply identifying signature strengths without doing anything with them proves the point. It had no enduring merit. It's easy to understand why. Dissonance theory, explored earlier, predicts that when you tell somebody

something at odds with what they believe, especially when it's about themselves, it leads to a rejection of the conflicting input. You feel weak, I tell you that you have strengths, you dismiss what I say as "things therapists are supposed to say to be nice."

The exercise, though, is about not only recognizing signature strengths, not only recognizing how they manifest in daily living, but deliberately, proactively, applying them in novel ways. In a sense, this is the behavioral equivalent of a posthypnotic suggestion: it is part of my job as the clinician to help you take what you learn in therapy and extend it across contextual boundaries in your life. Far more often than not, even when individuals have a particular skill or resource, or signature strength, they don't think to broaden its value by applying it in other relevant places. A goal of therapy, then, is to help clients use what they learn in therapy in whatever contexts it would benefit to do so. For example, you might only have talked specifically about being more compassionate with an elderly parent the client is feeling impatient with, but you can simultaneously create the possibility of being more compassionate with others as well by promoting the recognition that compassion matters in *every* relationship, not just the one with a parent.

Before assigning the exercise, you can provide a hypnosis session that goes from general to specific in first describing the different ways people discover strengths in themselves they didn't know they had, such as the people we see on television all the time who acted heroically in some desperate situation despite their protests that "I'm not a hero; I just did what I did." This suggests that people, including you, have resources you don't even recognize yet but may come to know and appreciate. Continuing the process and getting more specific during hypnosis, the therapist can label and reaffirm the merits of clients' signature strengths already previously identified. Picking one in particular to focus on and use as an example, the therapist can describe at least three different kinds of life situations where that signature strength would be valuable to employ. The greater the differences in the details of these situations, the better: we want clients to be able to recognize an opportunity to use the strength when the opportunities have different appearances. Part of people's limitations comes about from perceptual rigidity; unless the opportunity specifically looks like "this," they don't recognize it. This exercise helps teach people how to recognize opportunities to use their signature strengths in different contexts with different characteristics, and the hypnosis session can actively support that learning. Furthermore, the exercise encourages being proactive, presupposing a greater capacity for personal empowerment, which the hypnosis session can also fully support.

Gratitude Visit The therapeutic merits of this exercise lie in its ability to connect people in a direct and positive way and in encouraging the recognition that a path to feeling good, perhaps even the *strongest* path to feeling

good, is in doing good for others. Strong positive social connections are a vital component of mental health, as I explored in detail in my book *Depression Is Contagious* (Yapko, 2009).

When people get depressed, their tendency is to be self-absorbed. People isolate, and when forced to be around others, they often radiate the attitude, "Stay away from me." But self-absorption isn't contingent on depression. In fact, as Jean Twenge and W. Keith Campbell pointed out in their superb book *The Narcissism Epidemic: Living in the Age of Entitlement* (2010), self-absorption is growing as more and more people evolve the belief that little matters more than their feelings and getting their demands met. Higher expectations that are often unrealistic (e.g., "You can have it all"), greater emphasis on appearance (form) than substance (e.g., cheat to get the better grade to get into a better college), infatuation with celebrity and fame even if it's a vapid fame only for being famous, "relationships" that exist only in cyberspace, and other culturally induced perceptions lead too many in the direction of being disconnected.

Before assigning this exercise, you can conduct a hypnosis session that acknowledges that other people can be a source of pain but also a source of comfort and pleasure. You can draw attention to the fact that there are wonderful people out there in the world and there are some really bad people out there, too. You can emphasize how mastering the skills of learning to better distinguish the good from the bad and associating with the good ones is a far more valuable use of one's energy than withdrawing to avoid getting hurt or simply suffering alone. Moving from these general ideas to a more specific plan, you can remind clients that no one, but no one, succeeds without other people: we all rely on parents, teachers, friends, colleagues, mentors, spiritual leaders, and countless others across the life span. Clients can then be encouraged to think of at least three people who have contributed something valuable to their life, whether it be a recommendation for a good movie to see or book to read, or inspiration to adopt a profession, or just a memorable smile. Having clients in hypnosis not only recall but also actually revivify a powerful positive interaction is an experiential reminder there are good people in the world and that they need to be acknowledged. Then you can go on to ask whether there are any people, still living and available somewhere to be contacted if so desired, who made an important contribution that clients would like to acknowledge. The gratitude visit is thereby established as an obvious next step in this experiential process.

The fact that the gratitude visit generated a large positive effect in research subjects but of only a relatively short duration highlights the need, once again, to use hypnosis as a vehicle for helping people grasp the essential learning and apply it both regularly and across different contexts. Writing and delivering letters of gratitude is a fantastic way to reconnect people in positive and heartwarming ways, but it isn't necessarily practical to do regularly. Helping clients recognize the value of acknowledging people's generosity and kindness and how many different forms it can take in a given day is another

reframing: goodness is around you if you bother to notice and respond to it. The message is also that you can be the force that gives, and thereby receives, some of the best of what people can do. As Gandhi famously said, "Be the change that you want to see in others."

CONCLUSION

There is much that the field of positive psychology can learn from the field of hypnosis. The power of suggestion, the dynamics of attentional processes, the importance of creating a context that supports the exercises that shift people's perceptions about themselves and others, and the potential for generating fuller and more reflexive perceptions and behaviors that lead to greater self-awareness, enhanced character, and a sense of connection to other people and institutions are all compelling reasons to integrate hypnosis into the positive psychology framework.

FOR DISCUSSION

1. The first principle of hypnosis is that what you focus on, you amplify. Has the psychology profession's historical focus on psychopathology limited its value in any way? If so, how?
2. How do you determine when someone's optimism or pessimism is realistic in a given situation?
3. Some people think happiness isn't a worthy area of study or a worthy goal to strive for. Why do they say this, and do you agree or disagree?

THINGS TO DO

1. Do the gratitude exercise for at least a month. What do you notice?
2. Survey your classmates or others you know and ask them what they consider the top three human virtues or strengths of character. Are you surprised by what people tell you?
3. Identify your strengths and character virtues. How do these affect your style of practice in using hypnosis?

CHAPTER 13

HYPNOTIC HAZARDS, LEGAL CONSIDERATIONS, AND ETHICAL GUIDELINES

One of the misconceptions about hypnosis I discussed briefly in Chapter 2 concerned the potential harm to a client undergoing treatment employing hypnosis. I made the point that hypnosis could be applied skillfully and helpfully or could be misused and potentially cause harm to the client. It bears repeating: anything that has the potential to help has the potential to harm. In this chapter, I consider more carefully the hazards associated with hypnosis that make it essential to exercise caution and sensitivity in its use. I also describe some of the legal and ethical considerations associated with good clinical practice.

I have clearly mentioned many times the responsibilities a clinician has to clients and the range of skills necessary to treat them competently and ethically. When you hear examples of individuals who may have been harmed by someone treating them with hypnosis, you will likely recognize that when problems have arisen they haven't been due to hypnosis itself but rather to the way someone applied it inappropriately, poorly, or both. I cannot emphasize this point enough.

It is the measure of a field's maturity, in my opinion, when it can perform self-examinations with an openness to discovering the truth, even if the truth isn't all that pleasant. Due in large part, but not only, to the repressed memory controversy, the field of psychotherapy has had to come to terms with the reality that

well-intentioned psychotherapists can cause devastation to the lives of individuals and families. The field of hypnosis is maturing as well. There is a much greater willingness now to explore the issue of the untoward effects of treatments of all kinds, including the negative effects of medications and the number of patients coming out of hospitals sicker than when they came in from acquired infections.

IS HYPNOSIS INNATELY HAZARDOUS?

Historically, the hazards of hypnosis were rarely discussed, and when they were, the focus was a narrow one on the issues of whether hypnosis could be used to coerce people into engaging in antisocial behavior and whether hypnosis would cause psychological harm to emotionally unstable people. In fact, there have been reports in the clinical literature of negative effects following the use of hypnosis, including precipitating suicide or a psychotic reaction (Frauman, Lynn, & Brentar, 1993; Kleinhauz & Eli, 1987; Stanley, 1994), anxiety or panic (Judd, Burrows, & Dennerstein, 1985), difficulties in disengaging or re-orienting (Barabasz & Watkins, 2005; Orne, 1965), and physical discomfort such as headache, dizziness, or nausea (Coe & Ryken, 1979; Hilgard, 1974). With such reports as these, and others that I will consider shortly, it is no wonder that hypnosis has seemed at least a little bit risky to some.

Are these issues and reports something you should be concerned about? The answer is yes and no. Yes, there are potential hazards in doing hypnosis for you to be concerned and educated about. No, there is no evidence whatsoever that hypnosis causes psychosis, precipitates suicide, triggers panic, strips people of their psychological defenses, or otherwise harms people. There is a high level of consensus after all these years among hypnosis researchers and practitioners that hypnosis holds no inherent dangers when used appropriately by a well-trained clinician (Barber, 1995; Heap, 2008; Lynn, Kirsch, & Rhue, 2010; Perry, 1990). Encouraging focus and experiential absorption is not hazardous. What the person focuses on and gets absorbed in might be, however. The hazards are identical to those that apply to conducting a clinical practice where one is dealing with vulnerable people in distress. However, the greater intensity of the therapeutic alliance hypnosis affords can also intensify the relationship dynamics between a client and a practitioner (see Barber, 1995, for an excellent discussion of the interpersonal boundary issues in hypnosis).

WHO CAN PRACTICE HYPNOSIS? TRAINING AND CERTIFICATION IN HYPNOSIS

A client's psychodynamics, coping skills, quality of thought, level of defensiveness, motivations, attributional style, expectations, and many other such

psychological factors may be magnified in hypnosis. Might there be some negative effects as a result? Yes, so an advanced knowledge of these variables that comes from appropriate academic and clinical training is critically important.

While this may seem evident to most, in fact there are very few restrictions placed on who can legally practice hypnosis. There are many nonprofessional training programs that accept anyone who can afford the tuition as the sole entry criterion, and they provide their students with credentials and titles proclaiming their expertise. Many nonprofessional organizations offer credentials and titles to their members and have minimalist standards for membership. In fact, psychologist Steve Eichel (2010) wrote an amusing yet disturbing narrative about how he was able to get his cat, "Zoe D. Katze," credentialed as a "certified hypnotherapist" by two organizations and as a diplomate by a third. How can professionals trained in hypnosis as a complement to their more rigorous clinical training be distinguished by the uninformed general public who believes a "certified hypnotherapist" is well trained and credentialed?

The lack of a serious credentialing or licensure for hypnosis attesting to at least some minimal standards of training has been harmful to the reputation of hypnosis (Stanley, 1994; Voit & Delaney, 2004). The evidence is simply too substantial that when hypnosis is misapplied it can be a problem. Paraphrasing Martin Orne (1965), the guideline should be that if you're not qualified to treat the problem without hypnosis, then you're not qualified to treat the problem with hypnosis.

The American Society of Clinical Hypnosis (ASCH) and the Society for Clinical and Experimental Hypnosis (SCEH) responded to this challenge by each developing its own certification. ASCH and SCEH are hypnosis societies that limit their membership to qualified health-care professionals, meaning those with advanced academic degrees and appropriate state licensure to legally conduct a clinical practice. Both societies provide clear ethical and professional guidelines for the practice of hypnosis to their members, conduct national and regional trainings, offer referrals to the public, and much more. The certification in hypnosis that ASCH and SCEH offer can provide some measure of assurance to others, particularly consumers confused by issues about who is qualified to practice, that a certified clinician has attained a reasonable standard of education and experience. More information about ASCH, SCEH, and other professional organizations is available in Appendix A.

POTENTIAL HAZARDS ASSOCIATED WITH HYPNOSIS

The potential hazards people most associate with hypnosis, rightly or wrongly, include unintended interpretations of suggestions, spontaneous regressions and abreactions, symptom substitution and results that don't endure, confabulations, and failure to remove suggestions (Barabasz & Watkins, 2005; Weitzenhoffer, 2000).

Unintended Interpretations of Suggestions

Assuming you have been practicing your skills in hypnosis with different people, you have probably already discovered that people can and do respond in unexpected and even unusual ways to even the most straightforward hypnotic suggestions. The fact that people will interpret what you say from their own frame of reference, and will therefore associate meanings to what you say that you never intended, is a given in conducting clinical hypnosis sessions. It's to be expected, planned for, accepted, and utilized. Sometimes the unexpected responses you get are actually better than what you had hoped for: the person finds a simple word, phrase, or concept you mentioned deeply enlightening and transformative and radiates that wonderful perception. When that happens, it's wonderful. Other times, however, the unexpected responses you get are almost the opposite: the person finds something you said offensive, threatening, insensitive, or merely irrelevant. Sometimes it's because what you said really was offensive, threatening, insensitive, or irrelevant. More often, though, the person's association to what you said was idiosyncratic and simply couldn't have been predicted by you or anyone else.

Spontaneous Regression and Abreaction

This section identifies what is arguably the most common hazard of doing hypnosis: when the hypnotized individual flashes on some hurtful memory that was not suggested by the clinician (spontaneous regression) and becomes distressed (abreacts) as a result. The client's upset can range from mild to extreme and of course catapults the session into another direction that may or may not be related to what the original aims of the session were.

It isn't a question of *whether* you will encounter this phenomenon but *when*. For example, you might offer suggestions for the purpose of inducing hypnosis employing imagery, meant to be soothing, of being at the beach. As the person begins the process of relaxing, he nearly has a panic attack, simply because you didn't know that he had nearly drowned in the ocean as a young child. That piece of drama can occur even after you had the foresight to ask, "So, would it be all right to begin this process by having you focus on relaxing at the beach?" and he replied, "Yes, that's fine." Could the person really have forgotten that drowning episode, only to have it come up seemingly out of nowhere as you start to do hypnosis? Yes.

Memories can come up through deliberately structured age regression sessions conducted for some therapeutic purpose. Often, though, they simply arise spontaneously for people during hypnosis and engage the person's attention, hence the term *spontaneous regression*. That's natural and to be expected. After all, the events in our personal history have shaped our lives and are an inescapable part of each of us. We refer to our memories routinely in relating to ongoing life experience, so it's no surprise when someone flashes on

a memory triggered by some stimulus, such as your suggestions. Sometimes the memories are pleasant ones, but sometimes what come up are unpleasant memories that surface dramatically and with considerable emotional intensity. These are termed *abreactions*. When the emotions are positive and bring pleasure, it's not much of a concern to clinicians. But when the feelings are painful, involving hurt, grief, fear, rage, or whatever, the need for the clinician to know how to skillfully and therapeutically manage such feelings cannot be overstated (Lynn et al., 1996).

A spontaneous regression back to some unpleasant memory is an indicator of what is commonly called *unfinished business*, meaning personally significant experiences that didn't reach an adequate resolution and thus require further attention. Sometimes the suppression or repression of significant memories is so great that the material remains out of consciousness even during hypnosis and instead of there being an overt abreaction the person may complain of a headache or some such discomfort during or after hypnosis.

Even the most skilled clinician cannot know what land mines are in the client's unconscious waiting be tripped in doing therapy or hypnosis. What seems like a neutral term to one person may be the trigger to some intense personal experience for another. Therefore, the possibility of doing hypnosis without ever experiencing an abreaction is unlikely. Be ready by having good training in handling intense affect, the kind of training you are most likely to receive in advanced clinical workshops on working with people who have endured traumas of one sort or another.

Abreactions can manifest themselves in a variety of ways, including crying, hyperventilation, trembling of the body (or specific body parts), premature disengagement from hypnosis, hallucinations, delusions, and autistic-like rocking motions. Each of these behaviors is not automatically indicative of an abreaction but should be responded to cautiously and sensitively. Any sign of discomfort from clients signals an immediate need for you to clarify what's going on with them. "Checking in" is a good thing to do anyway, since one of the things well established through the phenomenological research of Peter Sheehan and Kevin McConkey (Sheehan, 1992; Sheehan & McConkey, 1982) is that someone can report being distressed even while maintaining an outward appearance of seeming calm and comfortable.

The means for "checking in" is straightforward. The first and foremost thing to remember in dealing with spontaneous regressions and abreactions is this: you can feel comfortable directly asking clients to describe their experience out loud. Give protective suggestions, and be supportive of their experience, using the general "accept and utilize" formula. Acknowledge and accept the abreaction, but be calming and helpful to clients in helping them reach a new perspective on the past experience. Use calming suggestions, make sure your voice is soothing and confident, and keep the session moving toward some form of resolution. In general, the best thing you can do is use hypnosis to resolve the situation and attain some closure. You do that by first supporting

the emotional release and then by guiding clients' attention in the direction of considering new perspectives, developing necessary coping and transcending resources, and helping clients to integrate them. Even if the hour is up, your responsibility to your clients isn't over. Make certain they can leave in a collected manner.

The specifics of how to manage traumas skillfully are beyond the scope of this introductory text, so I again encourage you to take more advanced clinical training with experts in this domain. If clients open up with some sensitive information that you are simply not equipped to handle for whatever reason, you can make sure they are immediately referred to an appropriate helping professional. Suggestions such as the following may be employed in such instances:

> … And you've become aware now of some feelings that are very strong and some memories that are needing some attention … and you can know comfortably that as these images and feelings drift into your awareness they can be handled skillfully … and you can help yourself by keeping this information in a safe place within you until they can be brought out with the person best able to help you with them … and so you can let these images and feelings drift to the safe place within you until you are ready to share them when the circumstances are right.…

Essentially, these suggestions are telling clients that they can "put the information away safely for now and deal with it later" in a context that is more appropriate. Such protective suggestions can have a very soothing effect on the person and can build even greater trust for your open acknowledgment of your limits in intervening. Following up to make sure clients get in to see someone qualified right away is critically important, as is staying aware of and supporting their overall well-being.

Symptom Substitution and Results That Don't Endure

Historically, the most common objections leveled against the use of hypnosis concerned the potential for only temporary results and a "symptom substitution." Symptom substitution is a psychodynamic theoretical construct that hypothesizes there is a psychic energy associated with internal conflicts that is relieved by the development of a symptom—an outlet for the energy. By removing the outlet, the theory suggests, the energy must be redirected elsewhere and a new outlet developed (Weitzenhoffer, 2000). In other words, the underlying psychological conflict generating the symptoms must be identified and resolved. If it isn't, presumably, the symptom will return or new equivalent ones will develop, thus called a symptom substitution.

As Barabasz and Watkins (2005) stated forcefully, "Even though researchers have shown these objections to be invalid … analytic writers continue to echo

the same criticisms, apparently with no awareness of the research and literature to the contrary" (p. 210). For one to charge hypnosis with this potential liability, hypnosis must necessarily be viewed as only a symptomatic treatment as opposed to a more dynamic or depth-oriented approach. Other "symptomatic" approaches, including the hugely popular and well-researched cognitive behavioral therapy, have faced this same theory-rich but baseless charge.

In the case of hypnosis, however, there is a twist that makes the response to the criticism somewhat complex: hypnosis can be used superficially and symptomatically. Scripted hypnotic approaches are an example of such methods. Is a symptom-oriented approach necessarily bad? Of course not. Helping someone cope with pain by teaching sensory alteration strategies in hypnosis, for example, isn't psychodynamically deep, but what a difference it can make in someone's life. Helping individuals with insomnia arising from anxiety or depression improve their sleep by teaching self-hypnosis to curtail ruminations isn't deep, but it's powerful, given how costly sleep disruptions can be.

There need not be any negative effects from hypnosis. Barabasz and Sheehan in an unpublished 1983 study (reported in Barabasz & Barabasz, 1992) obtained data from over 600 patients treated on a hypnosis and psychosomatic medicine unit in a hospital and had only one patient report mild, transient difficulties associated with his treatment. Their conclusion, which I support, is that psycho-education and psychological evaluations, including mental status exams, overwhelmingly precluded negative effects from hypnosis (Barabasz & Barabasz, 1992). It is a consistent finding across treatments and across clinical populations that informed clients perform better than uninformed clients.

The danger isn't symptom substitution. The real dangers are undertreatment, inappropriate treatment, and the potential for relapses. Simple, direct suggestions aimed at a target symptom can be used by untrained laypeople and poorly trained professionals with no real understanding of the deeper issues the person faces and, therefore, how their treatment may be misdirected. Thus, clients don't improve or may even get worse as proper treatment is delayed or precluded. Does the symptom serve some purpose? Does it affect mood, behavior, and relationships? Without an understanding of the multidimensional role of a symptom in a person's life and the related dynamics, symptom substitutions and relapses can be unwanted, unexpected outcomes. But it should be obvious these are a result of ineffective treatment and are not caused simply by using hypnosis.

Finally, the concern for results being only temporary is a concern of all treatment modalities, including psychodynamic ones. People may take steps forward, but they sometimes also take steps backward. Clinicians routinely strive to prevent relapses, for no clinician wants clients to enjoy only temporary benefits of treatment. Whether and how a clinician implements relapse prevention strategies into his or her interventions is obviously an important consideration. How long can a good hypnotic intervention last? Like a good idea, it can last a lifetime.

Confabulations

I have already alluded to the potential for false memories, and in Chapter 19 I describe in some detail the vulnerability of memory processes to suggestive influences. Here I succinctly describe some of the key points anyone doing hypnosis should know about this thorny issue.

When people don't remember some event or fact, they may fill in the memory gap with misinformation (e.g., fantasy material, inferences, misremembered information) without realizing it. The material projected into the memory gap is called a confabulation (Schacter, 1996). Confabulations may be self-generated, or they may be suggested bits of erroneous information that are incorporated as true. Confabulations and other "sins of memory" occur in people routinely and are not at all unique to hypnosis. Harvard University neuropsychologist Daniel Schacter (2001) described them and their pervasiveness in everyday life eloquently in his book *The Seven Sins of Memory: How the Mind Forgets and Remembers*.

In the course of hypnosis, when the lines separating imagination from reality may be even more blurred than usual, the danger is increased that someone will mistake a confabulation for the truth. This misperception can be a problem in therapy at any time, but it has been an especially serious one as clinicians struggle with the issue of how to best address the population of people who may have abuse (whether sexual, physical, or emotional) in their background. Such individuals may suffer a variety of memory problems as a direct result of the trauma (D. Spiegel, 2010). But memory gaps and errors can also arise for a number of reasons that have nothing at all to do with abuse. The danger, therefore, is in interpreting what a difficulty in remembering might mean. Gaps in memory may even be taken by some clinicians as evidence of abuse when in fact no such memories exist because there was no such actual history (Belli & Loftus, 1994; Lynn & Nash, 1994; Yapko, 1993a, 1994b). In such instances, it's the therapist, not the client, who confabulates about the client's memory gaps.

The means to avoid making the mistakes associated with the suggested memory problem can be stated unambiguously: don't infer a history of abuse where none is claimed; don't offer leading suggestions to clients in hypnosis about what and how to remember; don't assume a "root cause" that must be uncovered for every problem; do know the workings of human memory; do know the limits of hypnosis; do know that memories can be detailed and emotional and still be wrong; and be clear about the distinction between supporting versus validating clients' memories (Loftus & Yapko, 1995; Lynn et al., 1996).

Be reminded that there is no technology currently available to distinguish between truth and confabulation. Neuroscience is beginning to address this issue with the hope that sophisticated brain scans will one day be able to serve as truth and lie detectors, but that day is still quite far off. No clinician doing hypnosis should hold the terribly erroneous belief that hypnosis will reveal the truth.

FRAME OF REFERENCE: MARTIN T. ORNE

Martin T. Orne (1927–2000) was one of the most influential hypnosis researchers of all time. Unfortunately, I never had the occasion to meet Dr. Orne in person, one of my few professional regrets. Consequently, the quotes in this section are taken from his writings and not from personal communications as in most of the other Frame of Reference sections.

As a teacher, scientist, and practicing physician, Dr. Orne's expertise was primarily in the domains of hypnosis and memory distortion. Throughout his illustrious career, Dr. Orne collaborated with his wife, psychologist Emily Carota Orne. Their research on hypnosis and its effects on the accuracy of recall was cited in more than 30 legal cases by state supreme courts and the U.S. Supreme Court. His work was so highly regarded and influential that he was given awards for his lifetime contributions from the American Psychological Association, the American Psychological Society, and the American Academy of Psychiatry and the Law.

Born in Vienna, Austria, to a surgeon father and a psychiatrist mother, Dr. Orne moved with his parents to the United States in 1938. The Orne family settled in New York and then eventually moved to Boston. Dr. Orne received his bachelor's degree from Harvard University and his medical degree from Tufts University in 1955, did his residency in psychiatry at Massachusetts Mental Health Center, and returned to Harvard to receive his PhD in psychology in 1958. He was a professor of psychiatry and psychology at the University of Pennsylvania for 32 years before retiring as emeritus professor in 1996. Besides his seminal contributions to our understanding of the effects of suggestion on memory, Dr. Orne was also widely recognized for his work in biofeedback, pain management, sleep disturbances, and his exceptional analysis of the role of demand characteristics in hypnotic research in particular and psychological research in general. His contributions

to our understanding of the social context in which hypnosis takes place are profound. He was a prolific writer, publishing hundreds of scientific papers, many of which are referred to throughout this book and should be considered essential reading. Dr. Orne was also editor of the *International Journal of Clinical and Experimental Hypnosis* for 30 years. His interest in encouraging scientific research on the relationship between the mind and physical health and emotional well-being led him to establish the nonprofit Institute for Experimental Psychiatry Research Foundation. He served as its executive director until, shortly before he died, his declining health precluded him from continuing in this role.

Dr. Orne's expertise in memory distortion arising from suggestive influences and even from coercion led to his involvement as an expert witness in a number of famous and infamous cases. Among them was the 1981 trial of Kenneth Bianchi, the former security guard who confessed to being the so-called Hillside Strangler, the killer of five women in the late 1970s. Bianchi contended he suffered from multiple personality disorder, but Dr. Orne was able to cleverly prove to the court's satisfaction that this explanation was a fabrication. Dr. Orne was also an expert witness in the sensational Patty Hearst case. Hearst was the heiress who took part in a 1974 bank robbery after being kidnapped and held captive by a radical group known as the Symbionese Liberation Army. Dr. Orne testified to the role of coercion in her participation and drew upon his extensive knowledge of the phenomenon of mind-control tactics he had researched as part of his interest in demand characteristics and suggestibility.

Dr. Orne's research again took center stage when the false memory controversy developed in the mid-1990s. He helped expose the unfortunate methods of some psychotherapists who were unwittingly encouraging the creation of false memories of childhood sexual trauma. Dr. Orne used his considerable authority to drive home the point in his last years of work that he had first made as an undergraduate at Harvard in his very first published paper: Age-regressed adults are not literally reliving their early childhoods but are recalling them through the filters of adult understandings and perspectives.

Dr. Orne's lifetime achievements helped shape the modern practice of hypnosis in many ways. The following quotes from his writings can give you a glimpse of this very special man.

On suggested realities in hypnosis: "… An important attribute of hypnosis is a potentiality for the (subject) to experience as subjectively real suggested alterations in his environment that do not conform with reality" (Orne, 1959, p. 297).

On demand characteristics in human research: "A particularly striking aspect of the typical experimenter–subject relationship is the extent to which the subject will play his role and place himself under the control of the experimenter. Once a subject has agreed to participate in a psychological experiment, he implicitly agrees to perform a very wide range of actions on request without inquiring as to their purpose, and frequently without inquiring as to their duration. Furthermore, the subject agrees to tolerate a considerable degree of discomfort, boredom,

or actual pain, if required to do so by the experimenter. Just about any request which could conceivably be asked of the subject by a reputable investigator is legitimized by the quasi-magical phrase, 'This is an experiment,' and the shared assumption that a legitimate purpose will be served by the subject's behavior" (Orne, 1962a, p. 777).

On the potential harm to clients when the therapist is misguided: "The therapist using hypnosis, like any other therapist, will strive to ally himself with the healthy wishes and aspirations of the patient, but it is of course possible for a disturbed therapist to ally himself with destructive aspects of a patient's personality and facilitate destructive behavior" (Orne, 1972, pp. 113–114).

On being blinded by our desire to help: "We should keep in mind that psychologists and psychiatrists are not particularly adept at recognizing deception. We generally arrange the social context of treatment so that it is not in the patient's interest to lie to us, and we appropriately do not concern ourselves with this issue since in most therapeutic contexts it is helpful for the therapist to see the world through the patient's eyes in order to ultimately help him view it more realistically" (Orne, 1979, p. 334).

On more detailed memories not necessarily being more accurate memories: "Typically, age regressed individuals will spontaneously elaborate a myriad of details which apparently could only be brought forth by someone actually observing the events as they transpired. It is these details which sophisticated clinicians find most compelling and occasionally cause them to testify that they know with certainty that the individual was truly regressed. It is rare indeed, however, for the clinician to have the time, energy, or need to be certain that would cause him to verify the accuracy of an individual's description of events that transpired many years ago in childhood. Unfortunately, without objective detailed verification, the clinician's belief in the historical accuracy of the memories brought forth under hypnosis is likely to be erroneous" (Orne, 1979, p. 316).

On hypnosis and the courts: "Since it is widely believed by laymen that there is a virtual certainty of obtaining truthful information when a subject's critical judgment is diminished by either hypnosis or a drug, it is hardly surprising that efforts have been made to introduce hypnotic testimony in court as a way for the defendant to demonstrate his innocence to a jury. The courts, however, have recognized that hypnotic testimony is not reliable as a means of ascertaining truth and appropriately rejected both of these techniques as means of determining factual information" (Orne, 1979, p. 313).

On the efficacy of hypnosis in relation to individual hypnotizability: "… There is ample clinical evidence that the efficacy of hypnotic procedures is often unrelated to an individual's hypnotic talent.… This is not to say that the changes achieved necessarily rely on the same processes for persons with differing levels of hypnotizability. In some circumstances, the therapeutic benefit of a hypnotic intervention can be traced to nonspecific aspects of the therapy, yet the treatment response may be no less profound.… Hypnotic procedures can have an important

effect on the response of even low hypnotizable individuals, particularly in circumstances where the response does not require extraordinary hypnotic talent" (Orne, Whitehouse, Dinges, & Orne, 1996, p. 355).

On friendship: "Friendship is a complex process. It is sometimes hard, and often difficult to maintain. But it is joyous, too, and full of unexpected rewards. All that is really needed is the patience and commitment to make it work" (quoted by Bloom, 2000, p. 104).

On hypnotizability versus therapeutic responsiveness: "It is highly probably that hypnotizability in our sense does not correlate highly with response to therapeutic suggestion. This is indicated by a phenomenon that has long been recognized as puzzling: namely, that even a 'light hypnotic trance' may be sufficient to produce therapeutically marked changes in behavior" (Orne, 1966, p. 725).

On the development of a basic science foundation for psychotherapy: "The practice of medicine has sometimes been described as the art of making the right decision without sufficient knowledge. While great clinicians often intuitively transcend what is definitely known, the effectiveness of a field as a whole nonetheless depends upon the state of scientific knowledge. In order to illustrate the relationship of science to art in the context of psychotherapy, I ask my residents to imagine that they need their gall bladder removed and could somehow choose their surgeon from among Hippocrates, Pare, Billroth, or a second-rate surgical resident from a second-rate medical school in a second-rate hospital today. I then ask them to contrast this choice with the choice they would make if selecting their psychotherapist, given the option of Hippocrates, Rush, Freud, or Adler, or a second-rate resident in psychiatry from a second-rate medical school in a second-rate hospital today. Needless to say, their choice for the gall bladder operation is invariably in favor of today's medicine. Their choice of a psychotherapist, however, rarely favors contemporary practice.

In all healing professions the great clinician is preferred to the mediocre practitioner. Nonetheless, the measure of what is really known in a field is whether the midget of today can stand on the shoulders of the giant of yesterday, thereby becoming more effective than the great practitioner of the past. Though the role of art is likely to remain important in all healing professions, it is fair to ask why psychotherapy (which after all is ofttimes described as old as man himself) has failed to develop a readily transmitted body of cumulated knowledge that can ensure the competence of its average practitioner" (Orne, 1975, pp. 3–4).

There is no researcher more directly responsible for drawing attention to the vulnerabilities of memory in general and the vulnerabilities of memory in hypnosis than the late psychiatrist Martin Orne. Orne originated the concept of *trance logic* described earlier, and his pioneering research into the suggestibility of memory helped draw attention to the fact that people in hypnosis could give remarkably detailed accounts of an event, exude a high level of

certainty in the accuracy of their narrative making them quite convincing yet be quite wrong.

Failure to Remove Suggestions

A common fear expressed to me by students new to the field concerns the failure to remove suggestions. With all the things there are to occupy your mind while doing hypnosis, namely, formulating meaningful suggestions while closely observing and utilizing clients' responses, what happens if you forget to remove a suggestion? Will your clients stay age-regressed indefinitely? Will they stay anesthetized and live life "comfortably numb?" The answer is no. Is the failure to remove suggestions a legitimate concern?

It is a rare phenomenon, but it is possible that a suggestion may have a delayed or hidden effect beyond the hypnotic context (Damaser, Whitehouse, Orne, Orne, & Dinges, 2010). Therefore, your suggestions to clients, if meant to be temporary, should be structured to clearly indicate they are temporary. André Weitzenhoffer has probably written the most about this phenomenon and described the issue clearly when he wrote:

> It is not well-recognized that when the response to a suggestion is not allowed to be completed or is prevented from taking place there may be a lingering effect that may unexpectedly manifest itself sometime in the future. Furthermore, while it is usually assumed that if a response does not take place, this indicates the suggestion had no effect, this can be a quite erroneous conclusion. A related effect may take place also unexpectedly at some future time. While this may not be a frequent occurrence, it does occur. For this reason, I terminate or annul any suggestion that I do not plan to have an ongoing effect. (2000, pp. 53–54)

While Weitzenhoffer (2000) acknowledged that it is rare for a suggestion to linger beyond the time it is needed, his advice to deliberately annul suggestions is wise. Why are hypnotic responses generally temporary? Because they are "state specific" (Rossi, 1996, 2002). In other words, they are operative only as long as the person is in hypnosis. There is little or no carryover of the hypnotically obtained responses into the client's "waking" state unless there has been a suggestion to do so. Thus, if you forget to remove suggestions given during hypnosis at the end of the hypnosis session, the suggestion is highly likely to dissipate automatically upon disengagement.

If the exception occurs and the client continues to experience a suggestion that was not intended posthypnotically, the suggestion might have some special significance to the client. Hypnosis may be reinduced to explore its significance. The client may be rehypnotized and the suggestion removed in whatever manner is deemed appropriate.

LEGAL CONSIDERATIONS, ESPECIALLY INFORMED CONSENT

The climate for health-care providers has been and still is undergoing a remarkable transition in recent years. Some of the changes have been driven by the higher rates of litigation against health-care providers of all kinds. Malpractice suits, highly publicized ethical lapses, and even prosecutions for criminal behavior among clinicians may be brought to the attention of the general public through the media, stoking the fires of higher levels of expectation for receiving rapid cures for whatever ails us and, unfortunately, increasing the chances for disappointment as well. Not every health-care professional who gets sued deserves to be.

The legal guidelines associated with managing an ethical, responsible clinical practice in general obviously also fully apply to the use of hypnosis as well. While it is arguable whether hypnosis should be considered a therapy in its own right, all relevant parties agree it is, at the very least, a therapeutic tool that must be carefully utilized by qualified professionals.

The use of hypnosis in one's clinical practice may involve additional potential legal liabilities of which you must be aware. These grew to especially dramatic proportions in the wake of the repressed memory/false memory controversy. Many lawsuits established legal precedents for how hypnosis should be used when addressing memory related issues. But other issues involving hypnosis also arise in the legal arena, including who should be allowed to practice hypnosis, what defines malpractice, and so forth. Furthermore, professional malpractice insurance providers differ greatly from one another in how they view hypnosis as a declared part of one's professional practice. Some require extra liability coverage, and others do not. Health insurance providers also differ in their payment schedules when hypnosis is overtly involved. It is best to check with the various companies you deal with to learn their requirements, regulations, guidelines, and so forth. It is also a good idea to speak to the attorney representing your professional association to learn the legalities associated with the practice of hypnosis in the state or region where you offer your clinical services.

Informed Consent Is a Requirement

In the medical context, the doctrine of informed consent governs the physical treatment of patients. Patients are simply not to be treated without it. Informed consent gives patients the power to collaborate in their own treatment as knowledgeable participants. Doctors are required to give the patient a diagnosis, to explain available treatment options, to provide helpful data about the chances for successful intervention with the various options to help guide

the patient's choices, and even to explain the likely consequences of receiving no treatment at all.

Does the medical model of informed consent apply to the context of psychotherapy? How much information can a clinician provide without impairing the spontaneity and emotional power of his or her intervention? For example, can you imagine saying to a client, "I'm going to provide a paradoxical intervention now in order to indirectly encourage you to take a contrary position to my stated one because that's really the one I want you to take"? Despite informed consent obviously not fitting the psychotherapy context as well as a medical one, it remains an uncontested fact that people want to be informed and they do better in treatment when they are.

Hypnosis faces a number of specific vulnerabilities to the need for informed consent. One especially important one, highlighted in this section, concerns what is known in the legal realm as a "per se exclusion rule" regarding hypnotically obtained testimony (Giannelli, 1995). Many courts throughout the United States have adopted a per se exclusion rule that excludes the testimony of any witness, other than the accused, who has been hypnotized. Courts have relied heavily on the testimony of hypnosis experts who have said in no uncertain terms that hypnotically influenced testimony is inherently unreliable and should therefore be precluded from being offered into evidence.

This is an unfortunate and exaggerated response: hypnotically derived information can be unreliable but is not inherently unreliable. More prudent courts think of hypnosis as much the same as any other means of getting information: maybe it's wholly right, partly right, partly wrong, or wholly wrong and needs additional validation to evaluate it.

How might the per se exclusion, if it operates in your state, affect your practice? Consider this realistic case scenario. A woman is attacked and badly beaten. She seeks therapy for her posttraumatic stress symptoms. The therapist, with the absolute best of intentions, does hypnosis with this woman to reduce her distress and catalyze her recovery. The therapist did not know about or simply forgot about the per se exclusion rule, nor did the therapist know the assailant had been caught and the woman was going to have to pick him out of a lineup and then testify as a witness against him in court. You can probably see where this is going. When the defense attorney finds out she has been hypnotized for her posttraumatic symptoms, he files for a dismissal based on the inadmissibility of her evidence because it is presumably hypnotically tainted. She is unable to testify—end of case. (Not really, though, because that same client is likely to sue the therapist for not providing an informed consent that by doing hypnosis with her it would preclude pursuing her claim.)

Informing the client about possible memory distortions from hypnosis remains a controversy within the field and simply highlights the turmoil left in the wake of the repressed memory/false memory wars (Frischholz, 2001; Hammond, Scheflin, & Vermetten, 2001; Lynn, 2001; Spiegel, 2001).

Informed consent means patients must be informed about the treatment options available, the scientific merits of the treatments the clinician intends to provide, any untoward potential consequences of the chosen treatment, and the likely consequences of receiving no treatment (Scheflin, 2001). Informing the client about the research evidence for hypnotic procedures is growing in acceptance as simply good practice, even if not (yet) legally required.

ETHICAL GUIDELINES

The description of potential legal difficulties that may arise in the use of hypnosis indirectly comments on the need for formal education in the dynamics of human behavior, patterns of mind–body interactions, the intricacies of treating various clinical conditions, and the need to be deeply self-aware of one's own issues, needs, and motivations as well as knowing one's own limits in providing therapeutic interventions to others. Legal and ethical issues usually arise only when someone crosses a line they either didn't know about or else found inconvenient.

There are many ways to get into trouble in clinical practice, virtually all of them avoidable by being well educated enough and emotionally intelligent enough. Every professional association representing licensed, qualified clinicians in the United States, and as far as I know, internationally as well, has a code of ethics. The code of ethics spells out what constitutes appropriate and inappropriate conduct in exhaustive detail, and each person is tasked with knowing and honoring the code.

I assume that you are a helping professional and that you have only the best of intentions for your clients. I also assume, therefore, that the understandings of human nature and the capacity for interpersonal influence you learn here will be used in benevolent and even noble ways. Therefore, there is only a superficial coverage of the most basic ethical guidelines provided here:

1. The number one priority is to help, not hurt. If you feel that, for any reason, you are unable to work well with either the person or problem presented to you, then evaluate honestly whether it would be best to refer that person elsewhere and do so when appropriate. There are few factors, if any, more important than the therapeutic alliance in determining treatment outcomes (Cummings & Cummings, 2000; Duncan, Miller, & Coleman, 2001).
2. A professional's responsibility is to educate, not show off. Hypnosis lends itself to both. It is my sincere hope that the hypnotic phenomena you learn to induce are used and/or demonstrated only in appropriate clinical or educational settings. Furthermore, I would hope you are able to distinguish between your personal interests and what you choose to teach your clients. For example, there is no legitimate

basis for anyone to bring into clinical practice their interest in conducting past-life regressions or other such esoteric procedures. The goal of any treatment is to empower people, not disempower them by encouraging magical thinking.

3. Have your relationship with your clients as clearly defined as possible, including the nature of the intervention, the duration, the cost, the expectations, and evaluation points. Involving and educating your client will almost certainly make for a better, more productive relationship and will also meet the legal requirement for an informed consent to treatment (Frauman et al., 1993; Scheflin, 2001).
4. Do not go beyond your range of expertise or misrepresent yourself. Human problems are very complex and can't be reduced to a paragraph of dynamics. If you feel you are out of your league when presented with a problem, refer individuals to someone better able to meet their needs. Discussing cases with colleagues, continuing to get your information updated, and having peer supervision may help you keep your boundaries clear (Barber, 1995).
5. Presenting misinformation or the use of indirect techniques will sometimes be judged to be the best clinical approach. Be careful—such approaches can help a client, but they can also backfire. Have alternatives prepared every step of the way by thinking your intervention strategy through and taking all steps necessary to prevent untoward effects. In other words, be prepared.
6. Always involve, when appropriate, the proper qualified health professionals (Cummings & Cummings, 2000). When working on a physical symptom, for example, unless you are a physician you should have a medical referral and medical clearance to work with the problem. Practicing medicine (e.g., psychology, nutrition) without a license or without advanced clinical training, knowledge, and backup is illegal, unethical, and irresponsible.

There are many, many other considerations that go into conducting a competent, legal, and ethical clinical practice. Clinicians are generally well-intentioned people who want to do the highest quality work with their clients, but they sometimes get into trouble when they underestimate the complexity of what they're dealing with or when they don't know the hazards of a particular type of problem or treatment approach or when they overestimate their skills.

CONCLUSION

The issues and approaches presented in this chapter rank as some of the most important in this book. I hope they have sensitized you to the complex issues

associated with the responsible practice of hypnosis and also provided you with some comfortable guidelines for managing them well.

Working with hypnosis is inspiring in what it highlights about people's hidden resources, but there aren't many miracles to be had. There are just well-informed, well-designed clinical interventions that work.

FOR DISCUSSION

1. Have you ever experienced an abreaction? If so, in what context? What factors allowed the abreaction to occur? What consequences were there for you?
2. Have you ever experienced symptom substitution? If so, why? Have you been cured of symptoms that did not resurface in other forms? How?
3. What steps can you take to "expect the unexpected" in your caseload?
4. What differences are you aware of between something being "legal" and "ethical"? How and where is the dividing line drawn for you as an individual?
5. Do you think informed consent in psychotherapy should be mandated? Why or why not?

THINGS TO DO

1. Interview some traditionally oriented psychologists and psychiatrists, and ask them what dangers they associate with the use of hypnosis. Do you feel their responses reflect current knowledge? Why or why not?
2. Develop a strong referral list of a number of competent professionals in as many areas of health care as you can. Contact these professionals directly to be certain you know when a referral to them is appropriate and what their system for providing care is.
3. As an individual, but preferably as a class, create a list of ethical guidelines specifically for the practice of clinical hypnosis based on case examples contributed by each class member.
4. Talk to clinicians about how they address the informed consent issue in their practices and how it affects the treatment process.
5. Consult attorneys known for their expertise in hypnosis in your state (or country) and find out the local legal issues there relevant to your use of hypnosis.

PART II

PRACTICAL FRAMEWORK

CHAPTER 14

ASSESSING HYPNOTIC RESPONSIVENESS

We have previously considered suggestibility as a general human trait and how it manifests in a variety of ways ranging from conformity and obedience to authority to responding experientially to suggestions for imaginative experiences even in the absence of formal induction. Is suggestibility the same as hypnotizability? Hypnotizability is more specific than the general term suggestibility and can be defined simply: "Hypnotizability represents the individual's degree of responsivity to suggestion during hypnosis" (Keuroghlian, Butler, Neri, & Spiegel, 2010, p. 39). We have seen that hypnotizability varies substantially across people, a fact that virtually no hypnosis expert disputes. How to interpret that fact, though, is an ongoing challenge to the field. Many in the field think of hypnotizability as an individual's highly stable trait measurable with the use of standardized tests (Spiegel & Spiegel, 1978/2004). Others think of hypnotizability as more of a social and situational phenomenon that reveals itself through meaningful experience rather than as a response to standardized, impersonal test items. In this chapter, we explore the topic of hypnotizability testing and how the field treats the issue of whether and how to assess an individual's capacity for hypnotic responding.

THE CLINICAL AND EXPERIMENTAL DIVIDE

There is perhaps no one domain within the field of hypnosis that divides researchers and clinicians more than their sharply differing viewpoints about the use of standardized tests to assess hypnotic responsiveness in people. While research contexts demand such standardized testing to fully characterize research populations, the use of such tests seems to be undesirable to most clinicians, who apparently would rather learn from direct experience with

clients what their unique hypnotic talents might be. In a revealing survey by Barnier and McConkey (2004) of the articles published in the *International Journal of Clinical and Experimental Hypnosis* between 1992 and 2003, a sharp divide between clinical and laboratory researchers was evident: nearly all lab research studies employed testing, while 82% of the clinical research studies did not involve formal hypnotizability testing.

In one of the few studies of its kind, Sheldon Cohen (1989) surveyed faculty members teaching at an annual meeting of the American Society of Clinical Hypnosis (ASCH) regarding their use of formal measures of hypnotizability. Cohen discovered that only slightly more than half of respondents had ever used tests of hypnotic responsiveness, and of these fewer than a third were current users. As Lynn and Kirsch (2006) wrote, "We would wager that if the survey were re-administered today, the numbers would not be much different" (p. 206). I would wager similarly, for I regularly ask professionals in my clinical hypnosis trainings if they conduct hypnotizability tests and rarely does anyone claim to do so.

Encouragement for anyone who uses hypnosis to perform formal hypnotizability testing has greatly increased from within certain subgroups of the field whose members believe such testing will give hypnosis greater scientific respectability. The drive to define hypnosis in scientific terms has been a long time coming: experimental psychologist Clark Hull first brought hypnosis into the laboratory in the 1920s and later, while at Yale University, published the first scientific book ever on hypnosis with his classic work *Hypnosis and Suggestibility: An Experimental Approach* (Hull, 1933/2002). In this classic volume, Hull laid out valuable frameworks for conducting research with hypnosis that are still relevant today. Hypnosis as a topic suitable for experimental research has attracted many brilliant researchers, past and present, and their call for precision in describing hypnosis is entirely appropriate and justified. Realistically, though, the inherent ambiguities associated with hypnosis make precision an elusive goal.

The pressure to define hypnosis as a science has increased greatly in the last decade as the push within the health-care professions, especially psychology, has been to provide objective evidence for the effectiveness of specific forms of intervention. The intense demand from insurance companies, consumers, and allied professionals for proof that a method of intervention is an empirically supported treatment (EST) has catalyzed the drive from within the hypnosis community, primarily the researchers, for a more objectively measurable approach to the practice of clinical hypnosis. Many of the most influential people in the field have gone on record as strong advocates for not only the desirability but also the necessity of formal assessment of hypnotic responsiveness (Barnier & Council, 2010; Laurence, 1997; Lynn & Shindler, 2002; Nadon, 1997; Raz, 2007; H. Spiegel, 2007, 2008). Psychologist Ed Frischholz (2007) made a forceful point when he said, "… There is broad agreement that there is wide variation in response to suggestion and hypnosis. If we are

ever to explain why such variation exists, we must encourage the systematic measurement of these variations.… Therefore, I propose that assessing hypnotic responsivity become part of the standard of practice in clinical and forensic hypnosis just as it has in experimental hypnosis" (p. 191).

It is too soon to know whether or just how much the increasing call for testing will change the minds and practices of clinicians. Clinicians may appreciate the science of hypnosis but also believe hypnosis will always be at least as much about clinical artistry (e.g., judgment, adaptability, and creativity) as empiricism.

THE ARGUMENTS FOR STANDARDIZED TESTING OF HYPNOTIZABILITY

The previous discussion may begin to establish a foundation for the merits of hypnotizability testing. As a means of studying differences between individuals and specific group populations, hypnosis assessment tools provide similar benefits to other standardized instruments that reveal differences on other characteristics of interest, such as intelligence or memory. Without a means of standardizing test instruments, we lose the ability to correlate hypnotizability with any other trait or characteristic we want to test, such as treatment responsiveness or cognitive style.

I'll let some of the experts who advocate for formal assessment speak for themselves.

Psychologists and researchers Steven Lynn and Kelley Shindler (2002) summarized many of the most pointed arguments in favor of testing:

> Assessment can contribute to an understanding of the various components of hypnotic responsiveness and thus play a role in optimizing responsiveness to hypnotic procedures.… [Another] reason to assess hypnotizability is if there are great costs associated with the failure to hypnotize someone, or if there are clear benefits associated with a positive response to hypnosis … [and] assessment of hypnotizability is important because research has established that a link exists between hypnotizability and certain disorders and conditions and their successful treatment with hypnotic interventions. (pp. 187–189)

Psychiatrists Herbert and David Spiegel introduced another assessment instrument, the Hypnosis Induction Profile (HIP), discussed in some detail later, in their book *Trance and Treatment* (1978/2004) and stated the rationale for such instruments clearly: "Trance capacity, as measured by the Hypnosis Induction Profile, has a significant relationship to the total adult personality structure.… The assessment of hypnotizability is a useful diagnostic aid that can facilitate the choice of an appropriate treatment modality along the entire spectrum of mental health and illness" (p. 4).

Psychologist and researcher Ernest Hilgard was an especially strong advocate for formal assessment:

> The characteristic of an unscientific therapy is that there is only one disease and only one cure: such therapies imply that everyone can profit from the favored therapy regardless of the presenting problem. A scientific therapy is based on a diagnosis, which in psychotherapy means selecting the therapy of choice appropriate to fit the patient's condition. Hypnosis is only one of these choices, and its choice and the manner of its use can profit from some estimate of the individual's hypnotic responsiveness. (1982, p. 400)

Psychologist Ronald Pekala (2002) advocated for the use of formal assessments for quite a different reason when he suggested clients can benefit from knowing "where they stand" on the issue of hypnotizability. By knowing something about their own capacity as measured by a test, clients in therapy can live up to—or be motivated to even exceed—the measured capacity:

> Of course, if no actual assessment of hypnotizability is done before a treatment intervention, the client may not have a good idea as to how hypnotizable they actually are, because there are no salient clues to inform them of such. Some clinicians believe that without the clients' knowledge of their actual hypnotizability level, positive expectancy effects and placebo effects will engender positive therapeutic outcomes, regardless of hypnotic ability. Although this may be true with some clients, I believe it is better to have knowledge about a person's hypnotizability level and tailor a treatment plan to that level, instead of hoping that positive expectancy effects will do the rest. (p. 245)

Psychologists William Kronenberger, Linn LaClave, and Catherine Morrow (2002) acknowledged the value of an initial assessment such as those obtained through standardized instruments but went a step further when they advocated for the use of formal assessment on a session-by-session basis. The value of measurement information obtained in an individual clinical hypnosis session led them to develop their instrument, called the Hypnotic State Assessment Questionnaire (HSAQ). In describing the value of individual session assessment in addition to standard hypnotic responsiveness assessment, they wrote:

> Clinical hypnotic response quantifies a patient's behaviors and experiences in a single hypnosis session that is clinically focused, (usually) individually tailored to the patient's issues, and placed in the context of an extended treatment (usually involving multiple hypnosis sessions). The assessment of clinical hypnotic response typically is useful for such tasks as documenting a patient's response to a particular induction technique, evaluating the impact of a particular set of suggestions, keeping accurate and useful chart notes, monitoring change across sessions, and communicating with trainees about the response of their patients. (p. 258)

Attorney Alan Scheflin (2001) advocated for formal assessment for one simple reason: to reduce legal liability. By employing a standardized instrument, Scheflin believes, one's treatment plan can be viewed as being based on "scientific data about the patient" (p. 165). That may be a defensive recommendation, but in today's litigious environment it is not an unreasonable one.

THE ARGUMENTS AGAINST STANDARDIZED TESTING OF HYPNOTIZABILITY

More than a few clinicians and researchers have publicly expressed doubts about the merits of hypnotizability testing. In this section I will sample but a few of the opinions voiced by well-known experts on the matter.

Psychologist Michael Diamond (1989a), in the title of his article, asked, "Is Hypnotherapy Art or Science?" In the article, he asserted that standardized tests can provide only a general index of general hypnotic ability rather than objective measures of the specific abilities that will influence actual responses to therapy involving hypnosis. He suggested that little can be learned from a standardized test of hypnotizability that couldn't be better learned from more natural, less intrusive methods. He also cautioned that assessing hypnotizability actually poses some risks because the test scores could be a "misleading, intrusive, and transference-contaminating obstacle" to the therapy (p. 12).

Psychologist Stephen Gilligan (1987) made a similar point about the limits of standardization as it specifically applies to hypnosis, though more colorfully:

> … The standardized approach attributes both success and failure in the hypnotic encounter to the *subject*. The hypnotist is not that important. There are some major problems with this approach. First it assumes that a standardized induction, which essentially instructs a person to relax and imagine various things, is a valid way of assessing an individual's general hypnotic ability. This is like assessing dancing skill in terms of one's ability to do the fox trot. The point is that some people can disco but not waltz; others can square dance but not boogie, and so forth.… A second problem … is that it defines hypnotic ability in terms of *behavioral* responses to test suggestions. While using external behaviors to assess an internal state is understandable, especially in the experimental domain, it shades a major point: trance is primarily an *experience*, like love or anger, which will be different for different individuals. (pp. 7–8)

Psychologist and past president of the Society for Clinical and Experimental Hypnosis (SCEH) Joseph Barber (1989, 1991) also made an important distinction between one's hypnotizability scores and actual hypnotic capacity. He believes that hypnotizability scores are not especially helpful in predicting clinical outcomes. He also believes, however, that such scores might help

shape your approach to a client, suggesting that how direct or indirect you might be in offering suggestions may be influenced by the person's level and quality of responsiveness.

Unlike the others previously mentioned, who may not advocate for suggestibility testing but are not necessarily against it, psychologist Ernest Rossi (1989) was quite adamant in his dismissal of such tests when he said, "… Sensitive and humanistically oriented therapists avoid subjecting their already wary and weary patients to yet another power-trip, thinly veiled as 'an objective measure of hypnotic susceptibility'" (p. 15).

The most widely used hypnotizability assessment instruments, considered the gold standard by many in the profession, are the Stanford Hypnotic Susceptibility Scales (Forms A, B, and C). They were codeveloped by psychologists André Weitzenhoffer and Ernest Hilgard, names quite familiar to you by now. Thus, it may come as a surprise that Weitzenhoffer publicly took the position that the scales are largely irrelevant to clinical practice:

> If there is no real reason, besides the time required by doing so, against using scales in the clinical situation … it remains to consider why a clinician might want to use them aside from scientific reasons for doing so. Apart from this last, there seems to be little reason for it. This may come as a shock, being said by the main developer of the leading modern scale, and it has shocked many of my colleagues.
>
> The fact is that for many years this writer's position has been that from the standpoint of the everyday clinical practice of hypnosuggestion, using scales on a regular basis is not particularly useful for purposes of doing effective hypnotherapy. I must emphasize this last because some of my colleagues strongly advocate that clinicians routinely use an approved scale and some have upbraided me for advocating otherwise. But to what purpose? To show that one is a scientist as well as a clinician? Nonsense! There is much more than that to being scientific. (2000, pp. 276–277)

Commenting about the relationship between responses to test items and eventual responses to therapy, Weitzenhoffer (2000) went on to say:

> For one thing, such scales as are available test for specific effects. It is only to the extent that one can generalize from the response to a specific test suggestion to an entire class of more or less like suggestions that a useful prediction can be made. There is little evidence this can be done effectively … In the end, one usually has to go directly to the production of the desired effect to find out if it can be done.… Either the effect can be done when the time comes or it cannot.… Trial-and-error is most often the order of the day. (p. 466)

Clearly, there are wise and well-considered viewpoints advocating for virtually opposite positions on the use of standardized instruments for assessing hypnotic responsiveness. The environment in which you work, the degree of

FRAME OF REFERENCE: ERNEST R. HILGARD

Ernest R. "Jack" Hilgard (1904–2001) was one of the 20th century's leading psychologists. When he turned his attention to the subject of hypnosis relatively late in his professional life, he helped propel hypnosis into the spotlight as an area worthy of serious inquiry. Dr. Hilgard received his PhD in 1930 from Yale. His early career interest was in the area of learning. In 1933, he and his wife of 2 years, Josephine, who already had a PhD in developmental psychology, moved to Stanford where he soon became a full professor in the Department of Psychology. His early works are classics and include *Conditioning and Learning* (1940), *Theories of Learning* (1948), and his runaway best-selling introductory psychology textbook, *Introduction to Psychology* (1957). Hilgard stayed at Stanford University for the rest of his life, where he eventually retired as emeritus professor following his long and highly distinguished career. He was a past president of the American Psychological Association and a member of the National Academy of Sciences.

Together with André Weitzenhoffer, Dr. Hilgard established a hypnosis laboratory at Stanford in which countless valuable studies on hypnosis were conducted. They also trained the next generation of hypnosis researchers there, expanding the direction and volume of hypnosis research in the process. Drs. Hilgard and Weitzenhoffer cocreated the Stanford Hypnotic Susceptibility Scales, among the first and still considered by many the best objective measure of hypnotic responsiveness. Their widespread use in research continues to this day. Thus, directly and indirectly Dr. Hilgard helped shape the nature of hypnosis research in the decades beyond the time he first tasked himself with trying to understand hypnosis and hypnotic phenomena.

Dr. Hilgard is responsible for developing the Neo-Dissociation Theory of hypnosis, best articulated in his 1977 book *Divided Consciousness*. He developed the influential concept of the "hidden observer," a part of the person that could remain at least somewhat objective about ongoing events during hypnosis despite

whatever subjective experiences the subject might be having. Dr. Hilgard's findings on the differences in individual responsiveness to hypnotic suggestions led to his classic 1965 book *Hypnotic Susceptibility*, and his subsequent research on pain control through hypnosis led to his highly influential 1975 book, coauthored with his wife, Josephine, *Hypnosis in the Relief of Pain*. Dr. Hilgard, through his warm, gentle, and respectful demeanor and his encyclopedic knowledge of psychology and hypnosis, represented one of the very best the field has had. When the International Society of Clinical and Experimental Hypnosis reorganized in 1973, Dr. Hilgard served as founding president of the new International Society of Hypnosis (ISH). In 1997, ISH established in his name the Ernest R. Hilgard Award for Scientific Excellence, given to deserving individuals whose lifetime of published experimental work helps advance the field. Dr. Hilgard was instrumental in making hypnosis a respectable and worthwhile phenomenon to study in the laboratory and to practice in health-care settings.

On his interest in hypnosis: "I was at Yale as an instructor at the time that Clark Hull wrote his book on *Hypnosis and Suggestibility* (1933/2002), so I had some familiarity with it as a respectable topic for an experimenter. But at the time I was interested in moving my career in other directions. I didn't really participate in his work, though I think it made a difference to know that it would be a reputable thing to do. So, I started rather late in my career, after I had been well established in general psychology and particularly in the psychology of learning. I had the feeling that much of psychology dealt with rather superficial aspects of mental life. I thought it would be interesting to go into something that had more psychology in it. I felt that, in some sense, hypnosis really had psychology in it. How to get the psychology out of it, that's our own problem!"[1]

On the practical qualities of his research: "Although I define myself as one who adopts the generally accepted point of view toward hypnosis as a field of inquiry on its own, and deserving of its own theories, I have never been much of an advocate of comprehensive theories that go beyond the data of observation. I suppose this derives from my continued favoring of functionalism, even though I grew up in the era of behaviorism. The general principle I followed in designing my experiments, whether on conditioned responses or hypnosis, was to raise questions that were of somewhat limited scope so that the results held promise of dependable answers" (Hilgard, 1992, p. 86).

On the use of the Stanford Scales in Therapy: "I think that if I take just a sociological or political point of view, a scale is really very useful, and is more useful for clinicians than they like to admit. Whenever it's been tried on anything severe, like severe pain, there's no question that you have greater success with a more highly hypnotizable (subject) as measured by the scale, not as measured by some external method. Not that a person without a scale couldn't arrive at it by using various kinds of tests for analgesia and that sort of thing. From my point of view, that's the same kind of item you have on the scale anyhow. But if you want to use other (hypnotic) techniques (such as age regression) … it's kind of nice to know how readily you can get genuine age regressions where they relive their entire childhood."[1]

On defining trance: "I never use the word *trance*, so in that sense it's fair to say I'm less traditional. But these things are a matter of gradation. My own position, which I have described in neodissociation terms, is that you could have dissociations of various degrees.… [So] when people use the word trance they should really use it for a pretty massive set of dissociations so that you sense the personality change or that the whole orientation to reality is somewhat changed."[1]

On the need for clinicians to conduct limited hypnosis research: "It's the same problem in another sense with psychoanalysis. They never really wanted to do any real research. They thought psychoanalysis was itself a research method. You studied the individual and in a sense that's what Ericksonian treatment is—it's a research method to try and get a plan for the individual and if it works. But that isn't the way science is built. So if there's any message I have, it is to not get scientistic; you don't have to have analysis of variance and become a slave to statistics, [but at least have] just garden variety statistics. Here's half a dozen people that have these same symptoms; they've been treated in three different ways. Why were the different ways chosen? Was it just arbitrary? Why were some of them started in one way and then shifted to another? Put some little design into it."[1]

On the hidden observer: "… A hypnotized subject who is not aware of a sensory information may nevertheless be registering the sensory experience in some manner and processing the information.… The metaphor (of a 'hidden observer') may have been unfortunate because to some it suggested a secondary personality with a life of its own—a kind of homunculus lurking in the head of the conscious person. The 'hidden observer' was intended as merely a convenient label for the information source capable of a high level of functioning, not consciously experienced by the hypnotized person" (Hilgard, 1992, pp. 76–77).

On the importance of hypnosis in his career: "I would say that I really found the hypnosis period the most satisfactory in my career. I have this feeling that almost every time, even just in giving a simple scale of hypnosis, I learned something. It wasn't something I was necessarily ready to verbalize, but I learned about different kinds of responses to amnesia, or to age regression, or to hallucinated voices, and so on."[1]

[1] *Personal communication, August 14, 1988.*

affinity you have for testing, the importance placed on it by colleagues and teachers you have, and many other factors will have to be weighed by you to decide whether testing will be important in your practice of hypnosis.

MY PERSONAL BIAS ON ASSESSMENT ISSUES

I must admit to you now that I do not use formal suggestibility tests in my clinical practice. Philosophically, I am most aligned with the view of someone's hypnotic capacity as a potential that is mobilized under the right personal,

interpersonal, and contextual conditions. For one thing, the research about "low hypnotizables" improving markedly under adaptive clinical conditions (Gfeller & Gorassini, 2010) resonates with my own clinical experience with literally thousands of clients across more than 30 years of practice, highlighting for me that the standardized test score is less meaningful than the clinical response. For another, I am assessing clients' quality of focus and level of responsiveness to me from the moment we meet, but I do so through the course of our spontaneous interaction. Instead of attempting to discover if my clients are suggestible, I find it a much more practical use of my mental energy to discover how I can best structure my suggestions to increase the likelihood of their getting accepted based on their response style, attentional style, cognitive style, and other such self-organizing patterns of subjective experience.

For the clinician who does not share this perspective or who may not feel subjective assessments are reliable or adequate, formal suggestibility tests may be a useful tool. As noted already, there are some very good reasons for wanting to use them. Ernest Hilgard has been among the most forceful advocates for testing, and with good reason. His research has yielded a treasure trove of insights about hypnosis, and these have had a profound impact on the field.

GENERAL FUNCTIONS OF HYPNOTIZABILITY TESTS

The chief purpose of hypnotizability tests is to determine the person's degree, if any, of ability to respond to suggestions given in hypnosis. Hypnotizability is generally defined in testing conditions as *behaviorally manifested* evidence of having responded, in whole or in part, to the clinician or researcher's suggestions for various kinds of experiences. Hypnotizability tests can be divided into two general categories: formal and informal. Examples of each will be presented shortly.

Beyond determining hypnotizability, tests can serve a number of other purposes as well. For example, by using tests to measure responsiveness, the testing process and derived scores can yield insight into what approaches may be best—that is, easiest to relate to or most comfortable to assimilate—for a particular client. Specifically, should your approach primarily be direct or indirect? Should your suggestions mostly be positive or negative? Should your demeanor be commanding or easygoing? Can clients respond readily, or do they require extra time? Striving to answer such questions presupposes a willingness to adapt your approach to individual clients. Some clinicians take the position that this is neither necessary nor desirable. Obviously, I disagree.

A second positive purpose of the hypnotizability test is to serve as a conditioning experience for entering hypnosis. The formal test is, in a way, an abbreviated version of the hypnotic encounter. By having clients focus their attention on an induction process and then respond to requests to generate

hypnotic behavior, you provide what may well be a first "official" hypnotic experience for them. Use of this initial experience as a foundation for future similar experiences starts to condition clients: they learn to enter hypnosis while being guided by the clinician. Thus, they have an opportunity to build a therapeutic alliance with the clinician while beginning to build confidence in their ability to experience hypnosis.

A third helpful function of the hypnotizability test is its ability to accomplish what can be called *prework work*. If the test is introduced as merely a preliminary to the "real" therapeutic work to be done, it can be an opportunity to catch the client "off-guard" and offer some therapeutic suggestions that may be less subject to critical analysis. Saying something such as, "Before we begin, do you already know you're capable of focusing your attention?" begins to elicit relevant resources despite not formally having begun the process yet.

STANDARDIZED INSTRUMENTS FOR THE FORMAL ASSESSMENT OF HYPNOTIC RESPONSIVENESS

Weitzenhoffer (2002, p. 209) noted, "As of 1998 … there existed at least 25 instruments variously called scales of 'hypnotic depth,' of 'hypnotic susceptibility,' of 'suggestibility,' of 'hypnotizability,' and variations thereof. I am fairly sure I missed other existing ones and, most likely, new ones have cropped up since then." Then he asked bluntly, "Why so many? Do we need all of them?" (p. 209).

Why, indeed? It is far beyond the scope of this introductory text to name and describe the many instruments available. Instead, I will acquaint you with three hypnotizability tests that are among the most widely employed by researchers and clinicians in the field.

The Stanford Hypnotic Susceptibility Scales (SHSS)

In 1957, Ernest Hilgard and André Weitzenhoffer, as the principal investigators, began comprehensive studies of hypnotic responsiveness at Stanford University. By 1959, they had developed two alternate forms of a scale that came to be known as the Stanford Hypnotic Susceptibility Scale (SHSS): Forms A and B (Weitzenhoffer & Hilgard, 1959). Two forms were developed to permit repeated measures without results getting distorted from a "practice effect." The scale consists of 12 items, with instructions for each item fully scripted for wording to be exact and replicable by whomever is administering the test. There were, of course, objective criteria for scoring each item, yielding an overall score reflecting hypnotizability.

In Form A, the test items included a "postural sway" (suggestions of standing, swaying, and involuntarily falling backward), eye closure (suggestions for

feelings of fatigue in the eyes and a desire for closing the eyes), hand lowering (arm extended, suggestions given for heaviness), a "finger lock" (fingers are interlocked and suggestions are given the hands will be difficult to pull apart), a fly hallucination (suggestions for an imaginary fly buzzing about to be swatted away), posthypnotic suggestion for changing chairs (suggestions given that after hypnosis, a pencil tap would lead the subject to change chairs and have no recollection as to why), and several other items. When subjects respond within the allotted time and in the suggested way to an item, they get a point for that item. Very high hypnotizables, often referred to as *hypnosis virtuosos*, as you would predict, score positively on all or nearly all the items (11 or 12). Forms A and B were generally well received by the profession. However, since most of the items involved motoric responses, and because it did not distinguish well more specific characteristics of the highs, Weitzenhoffer and Hilgard (1962) went on to develop a third form of the SHSS, Form C. It was intended to highlight more of the cognitive elements of hypnotic experience. It, too, features 12 items but includes different items that examined distortions of perception and memory and presents items in an ascending order of difficulty, with a point given for each positive response. All forms of the SHSS take approximately 1 hour to administer. Very highs score 11–12, highs score 8–10, mediums score 5–7, and lows score 0–4.

The SHSS is probably the best researched and most widely used instrument for establishing norms within and across populations, including cross-national populations in Mexico (Sánchez-Armáss & Barabasz, 2005), Israel (Lichtenberg, Shapira, Kalish, & Abramowitz, 2009), Italy (DePascalis, Bellusci, & Russo, 2000), and numerous other countries. It has also been modified for a variety of special purposes (see Weitzenhoffer, 2000, for a detailed consideration). As mentioned earlier, many consider it the gold standard by which other hypnotizability tests are measured.

Harvard Group Scale of Hypnotic Susceptibility (HGSHS)

In 1962, Ronald Shor and Emily Orne devised a group version of the SHSS:A, which they called the Harvard Group Scale of Hypnotic Susceptibility, Form A (HGSHS:A). The next year, they reported the normative data (Shor & Orne, 1963). It was designed to be administered to group sizes of up to 20 people simultaneously, thus making it much more time-effective for researchers working with larger pools of research subjects. For this reason, it's possible that more people use this test than the SHSS:C. Like the SHSS:A from which it was adapted, it includes 12 items and takes about an hour to administer. Unlike any of the SHSS forms, which are administered in a live format, the HGSHS:A is group administered by a recording. It was first designed as a preliminary screening tool, a nonthreatening way to get an initial impression of hypnotic responsiveness, but the time-saving factor of testing 20 people

simultaneously instead of only 1 in 1 hour became a very attractive advantage to examiners. The HGSHS:A has also been tested for cross-national norms in Australia (Sheehan & McConkey, 1979), Sweden (Bergman, Trenter, & Kallio, 2003), Korea (Pyun & Kim, 2009), Poland (Siuta, 2010), and many other countries.

Hypnosis Induction Profile

The Hypnosis Induction Profile (HIP) was developed primarily by psychiatrist Herbert Spiegel, joined later by his son David Spiegel (1978/2004). Unlike other hypnotizability scales, the HIP was developed in a clinical setting with patients in treatment where the "motivation is likely to be greater because the patient is seeking help with a personal problem rather than exercising curiosity" (p. 38). They were dissatisfied with the SHSS and HGSHS:A because of the length of time they took to administer, and they thought several of the items were potentially too embarrassing.

The HIP involves items similar in structure to the SHSS and HGSHS:A, such as arm levitation and amnesia, but has the unique additional feature of the "eye-roll" test:

> In the course of informal clinical observation over the years, one phenomena seemed to emerge with striking regularity. Those subjects who turned out to be deeply hypnotizable had impressive capacity to roll their eyes upward. Extra-ocular eye movements seemed more mobile and expressive. In contrast, those patients who turned out to be non-hypnotizable, did not in general, show this mobile extra-ocular movement. (Spiegel, 1972/2010, p. 15)

Subjects are told to roll their eyes up as if looking through the top of their head (the "up-gaze" part of the test) and then to strive to close their eyes (the "roll" part of the test). The amount of the sclera (whites of the eyes) showing as the eyes raise and then the eyelids close over the upturned eyes, each rated on a five-point scale, are added together to yield the "eye-roll sign" score, which indicates level of hypnotizability. The Spiegels hypothesized that the eye-roll sign is a manifestation of the way the brain hemispheres interrelate and serves as a "biological marker" of hypnotizability. The HIP has the advantage of taking only a few minutes to administer, and the Spiegels suggest the test can even become the induction for therapeutic work in hypnosis, thereby giving a more flowing element to the clinical interaction.

The HIP does not correlate significantly with the SHSS or the HGSHS:A. Frischholz and Nichols (2010) explained why:

> In the 1972 paper, Herb firmly indicated that the Eye Roll *predicts* hypnotizability. It does not directly measure it. Hence the correlation between

> Eye Roll scores and measured hypnotizability was not significant in 25-30% of the patient sample. Others mistakenly considered the ERS (Eye Roll Sign) to be a direct measure of hypnotizability instead of the entire HIP. (pp. 7–8)

Herb Spiegel (2008) summarized the merits of the HIP this way: "… when the *Hypnosis Induction Profile* is used to measure hypnotizability (it takes only 5 to 10 minutes), four levels of information become evident: 1) trance capacity—high, mid-range, low; 2) personality processing style; 3) placement on a health-illness continuum; 4) which strategy is appropriate, given the data from 1–3" (p. 151).

The HIP remains a popular instrument for its convenience, short duration, and clinical foundation.

INFORMAL ASSESSMENT OF HYPNOTIC RESPONSIVENESS

As mentioned already, most clinicians do not employ formal instruments for assessing hypnotizability, for reasons ranging from the complaints that they "feel" artificial or set up "pass–fail" situations needlessly to the belief they don't reveal useful clinical information.

Psychologist Brent Geary (2001) summed up his preference for more naturalistic ways of gauging hypnotic responsiveness when he wrote:

> [My] premise is that everyone with intact mental processes can benefit from hypnosis to some degree. The extent to which this is possible is tested through clinical intervention rather than by the administration of a set procedure that yields a quantifiable result.… The primary context for assessment … remains the patient's ongoing narrative and responsiveness in the psychotherapeutic relationship. (p. 3)

Weitzenhoffer (2002) also downplayed the value of formal testing in clinical situations, instead recommending a "just do it and see what happens" approach:

> There are psychologists and psychiatrists who feel that every prospective psychotherapy patient should be routinely widely assessed and that this should include assessments of hypnotizability and the like. I have seriously questioned any practice of routinely including tests of hypnotic responsiveness in the test batteries that may be used. I have yet to hear convincing reasons for doing so. Any testing should be guided for a specific need for it. In this regard, many practitioners seem to feel that if they know ahead of time how suggestible their patient is they will be better able to plan the therapy. I agree that if one plans to use a specific hypnotic effect one needs to first know whether it can be produced. There is no better way to do this than to go ahead and produce the effect.… I hear complaints on

> the part of clinicians that the scales do not give information relevant to the clinical outcome of the use of hypnotism. True, but it needs to be kept in mind that the scales were not designed with that aim in mind. (pp. 216–217)

Previously, Weitzenhoffer (2000) commented, "Either the effect can be done when the time comes or it cannot" (p. 466). Thus, many clinicians prefer to simply observe responses as they unfold in the "real-life" context of the therapy. Responsiveness is seen as existing in the context of the interaction rather than as solely a function of some innate characteristics of the client.

What are some of the ways to assess responsiveness from this more informal perspective, that is, besides the formal standardized tests already described? Some people use structured "mini-tests" such as the Chevreul's Pendulum, the Hot Object, and the Hand Clasp, described next. But the Embedded Commands and Nonverbal Shifts, described after the mini-tests, are the kind of nonintrusive, more natural forms of assessment that many clinicians prefer to rely upon.

Chevreul's Pendulum

This is a structured mini-test typically administered before formal hypnosis as a simple means of helping the client get "acquainted with hypnotic-like responding" (Bates, 1993, p. 40). If you have ever played with a Ouija board, you've experienced the Chevreul's Pendulum test. A pendulum is given to the subject with the instruction to hold the chain between thumb and forefinger (Barabasz & Watkins, 2005; Lynn & Kirsch, 2006). The process can be made a bit more dramatic by having the subject hold the pendulum over the center of a circle containing intersecting lines drawn on a piece of paper. The circle may look like that shown in Figure 14.1, titled the "Chevreul's Pendulum Field of Response."

The vertical axis was labeled "Y" arbitrarily to stand for our cultural head nod to respond yes. Likewise, I arbitrarily labeled the horizontal axis "N" to stand for our cultural head shake to respond no.

Once the subject has the pendulum dangling over the center of the circle, suggestions such as the following can be given:

> As you relax by breathing deeply, you can concentrate on holding the pendulum still.… That's right … and now as you continue to concentrate you'll notice and allow the pendulum to take on a particular motion. [Notice the lack of specificity in the suggestion about what motion the pendulum is to

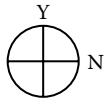


Figure 14.1
Chevreul's Pendulum Field of Response.

> take. As you observe the pendulum begin to move, you can then begin to use additional suggestions to amplify the movement.] That's right.… The pendulum can begin to swing more and more along the (N, Y) axis, from (left to right or to and fro), and it can do so without you really knowing how or why.… The pendulum can move just by your concentrating on it, and you can concentrate on letting it swing wider and wider without any effort on your part.…

Then you can further suggest stopping it and switching directions to the other axis. The greater the degree of the pendulum's swing, the greater the degree of responsiveness.

As hokey as this old test may seem, it does illustrate well the transderivational search and ideomotor processes first discussed in Chapter 3. As clients process the meaning of "left to right" or "toward you and away from you," their body responds to the mental meaning and causes small muscle movements called an *ideomotor response* outside of consciousness that cause the pendulum to move. Since the small muscle movements are unconscious, the swinging pendulum is often a genuine surprise to clients and thus serve as a convincer of their hypnotic skills—and yours as well.

The Hot Object Test

Like most tests, this one involves translating suggestions into physical responses, specifically a sensory hallucination of warmth in an ordinary object. In this technique, subjects have their eyes closed and are given an object to hold in their hand, such as a coin or a pen. Then they are told it's going to begin to heat up. Suggestions might be given that the object has been treated with a special chemical or is perhaps plugged into an electrical outlet and that it will begin to heat up and get hotter and hotter until it becomes too hot to hold.

I have a video clip of Ernest Hilgard demonstrating this technique in his Stanford lab with a woman he hands an ordinary ballpoint pen to while she focuses her gaze elsewhere, away from him. He tells her it is a "heating element" that he is going to plug into the wall. He instructs her to tell him when it starts to get warm, which she does almost immediately. Then he tells her it will get hot, too hot to hold, and to drop it when it does so. She breathes heavily trying to hold on as long as she can before she drops the pen. She had the subjective experience of the pen getting too hot to hold. The length of time it takes the object to "heat up" and the degree of heat sensation the subject experiences are the measures of responsiveness in this test.

The Hand Clasp

The Hand Clasp is one of the subtests of the Stanford Hypnotic Susceptibility Scale. It involves a challenge to clients to perform a suggested behavior. First, they are asked to sit comfortably, hands together and fingers interlaced. Then

some suggestions are offered about their hands being stuck together somehow, perhaps with glue. Following these, clients are challenged to try to pull their hands apart. The typical suggestion is, "The harder you try to pull your hands apart, the more tightly stuck together they become."

There is a play on words in this mini-test. It concerns the difference between *trying* and *doing*. Trying implies expending energy but not actually doing. The key suggestion for this and other similarly structured tests is phrased, "The harder you try to (pull your hands apart, bend your arm, open your eyes), the more difficult it will be to do so." The tendency some people show for literal interpretation of suggestions is what allows this technique to work (when it does). The next step then is providing the suggestions that "in just a moment I'll ask you to separate your hands (bend your arm, open your eyes) and let them drop into your lap … and you'll be able to do so quite easily, quite effortlessly.… Now go ahead and separate your hands and let them drop slowly to your lap." Notice the difference between the try challenge mode and the do mode.

Another variable in this and each of the challenge tests is the amount of time you give the person to try. Let individuals make the initial effort, find it takes more energy than expected, and then give them the suggestion to "stop trying now and just continue to relax." If you give them more than a few seconds to feel that initial effort, of course they can eventually do what you've suggested couldn't be done. Be quick to let them stop trying.

Finally, you can appreciate the concern of some clinicians who prefer to avoid tests that challenge persons in any way. As Lynn and Kirsch (2006) recognized, "The failure to pass suggestibility tests could dampen positive treatment expectancies and motivation and therefore beget treatment failure" (pp. 206–207).

The three informal tests described here are structured ones that are commonly used. They are obviously quite arbitrary and ritualistic in terms of the demands they make on clients. However, there are other, more spontaneous approaches to assessing suggestibility as well, two of which are described in the following sections.

Embedded Commands

Embedded commands, also known as injunctions (Zeig, 1988), are suggestions for specific responses that are integrated into the context of a larger communication. By being smaller components embedded within a larger communication, they are suggestive but do not stand out as such and thus can more easily escape conscious detection. For example, if I use my voice to accent or emphasize slightly, perhaps through a change of voice tone or volume, the underlined words as I say the following sentences, I can embed suggestions for specific responses:

- "Isn't it nice to … *close your eyes* … at the end of the day?" (I may get the eye closure response, an obvious indicator of suggestibility)
- "I thought to myself I could … *take a deep breath* … and think it over."
- "You can … *scratch the itch* … to succeed."

If you offer a suggestion so indirectly and the person takes a deep breath or scratches an itch, you have a positive response to what Zeig (1988) called minimal cues. Any suggestion that's embedded has the potential to get a response. More spontaneous, less imposing, and arbitrary than challenge tests or gimmicks like a pendulum or glued hands, embedded commands can be a more useful, natural indicator of responsiveness.

Nonverbal Shifts

Nonverbal shifts in unconscious behavior can also be a good indicator of suggestibility. Part of attaining rapport is the "mirroring" of client behaviors outside their consciousness. Nonverbal shifts can take place in many behaviors: posture, gestures, scratching, eye contact, and breathing, to name just a few. If you mirror a client's body posture then shift your posture and your client shifts similarly at that same moment, you have evidence of rapport and suggestibility at an unconscious level. In one of my clinical demonstration sessions, for example, I am working with a depressed young man named Mike. As I orient Mike to beginning the hypnosis session, I unconsciously leaned back in my chair and crossed my legs. Just a second later, he does exactly the same. I knew at that moment that the connection between us would likely help make the session useful to him, which long-term follow-up shows it was.

Mirroring someone is effective only to the degree that it remains out of clients' consciousness. If perceived consciously, it's no longer called attunement; rather, it's called mimicking, and rapport will be lost. It's important to be careful and respectful in using these types of indirect techniques.

SOME FINAL TIPS ON PERFORMING ASSESSMENTS OF HYPNOTIC RESPONSIVENESS

Introducing and performing suggestibility tests requires as much skill in communication as any other aspect of working with clinical hypnosis. There are the matters of timing (i.e., when in the relationship it is introduced), the explanation of a test's role in treatment, the style in which you offer it, your response to the client's response or lack thereof, and how you end it and move on to the next phase of interaction.

Some clinicians use suggestibility tests right away—even before the person's problem is presented, even before rapport is attained. I strongly discourage

that practice, but, still, it's what some people do. To my way of thinking, rapport is essential and must be earned through clinical skill.

CONCLUSION

The broad questions of why and how people vary in their hypnotic responsiveness have already received massive attention in the research literature. These are important though difficult questions that underscore the unifying principle for all researchers and clinicians interested in hypnosis: we want people to benefit as much as possible from hypnosis, and we're each in our own way trying hard to find out how to make that happen.

FOR DISCUSSION

1. Have you ever played with a Ouija board? What was your reaction to it? How did you explain what happened?
2. How do you know when someone is open to your suggestions? What "body language" do you equate with open- and closed-mindedness? What exceptions are you aware of?
3. How responsive do you think you are to others' suggestions? What makes you think so? Do you view your level of responsiveness to others as an asset or liability? Why?
4. One person yawning reliably triggers the yawning response in others. What other suggestions are you aware of that people seem to react to automatically?
5. What does *unconscious rapport* mean? How do you know when you have it?

THINGS TO DO

1. Get hold of the assessment instruments described in this chapter, and others as well, and spend some time studying them—their structure, their wording of suggestions, their assumptions.
2. Engage several people in a Ouija game who have no background in hypnosis and, ideally, who have no experience with the Ouija board game. What do you observe? How do they explain what happened to them?
3. The next time you shop, engage salespersons in a discussion first about a product you intend to buy, and another you have no intention of buying. What differences are you aware of in your internal experience in

the two conditions? How do your feelings and behavior differ in the two conditions?

4. Practice each of the suggestibility tests on at least 10 different people. Alter your style from authoritarian to permissive, and notice each person's response to your guidance. What do you learn about differences in response style? What explanation do you have for these differences?

CHAPTER 15

STRUCTURING SUGGESTIONS

Suggesting to someone that he or she go to, or perhaps avoid, a particular restaurant or movie is a routine type of interaction. Despite its commonness, this kind of interaction can illustrate the nature of suggestion quite well. In making a recommendation of any sort, you are sharing information with people about an experience you've had or an opinion or belief you hold. On the basis of your restaurant description, for example, the person you're speaking to forms internal representations of your experience, perhaps vividly imagining what the restaurant looked like, what the atmosphere was like, how the service was, how the presentation of the food was, how the food tasted, and so on. If it is a powerful enough positive representation, it may motivate him or her to go there and have a similar experience directly. You didn't issue a command to go there—just a suggestion for the possibility.

The power of hypnotic communication—that is, communication that absorbs individuals' attention and directs their experience—is in its ability to act as a catalyst for organizing and using more of their internal resources, both conscious and unconscious. Persons in hypnosis are focused and capable of responding to suggestions more experientially and multidimensionally. Does the quality of suggestions you offer play a significant role in facilitating absorption and experiential responding? Most definitely, as both clinical and experimental evidence confirm (Barabasz, Barabasz, Jensen, Calvin, Trevison, & Warner, 1999; Gafner & Benson, 2003). In this chapter, I consider the structures and styles of suggestions; these represent the "nuts and bolts" of hypnotic communication.

SUGGESTIONS ARE INEVITABLE, BUT THERE'S NO GUARANTEE THEY'LL BE ABSORBED

The skills of an effective practitioner are found in the ability to formulate suggestions in such a way as to make them both acceptable and usable to the client. Merely performing an induction of hypnosis is not sufficient for building receptivity. Likewise, a deep hypnotic experience on the part of clients provides no assurance that they will accept offered suggestions, even those that are clearly in their best interest to accept. Any suggestion can be accepted or rejected, whether delivered during hypnosis or not. As you have learned, numerous personal, interpersonal, and situational factors ultimately synergistically determine the qualities of people's responsiveness to suggestion. There are many different ways of communicating an idea to someone, so the clinician's task is to be mindful of choosing a means of organizing and delivering suggestions that carries the greatest chance of being accepted by the client.

SUGGESTION STRUCTURES AND STYLES: THE CHARACTER OF HYPNOTIC COMMUNICATIONS

Suggestions are dynamic, not static in their structure. They can range and vary along a number of different parameters simultaneously. In clinical practice, there is no time when all your suggestions will fit into only one category—on the contrary, for you'll regularly move up and down each particular continuum of suggestion structure and style as you offer suggestions to someone. What are these continua? On one continuum of suggestion, we have suggestions that range from positive to negative. On a second continuum, we have direct and indirect suggestions occupying the poles. On a third continuum, we have process and content suggestions. On the fourth and last continuum, which characterizes the style in which the suggestion is offered, we have possibilities ranging from permissive to authoritarian. In a related but separate category are posthypnotic suggestions, an essential and well-considered part of any clinical intervention. Table 15.1 summarizes the suggestion structures and styles.

Let's consider each of them in turn.

Positive Suggestions

Positive suggestions are by far the most common, simplest, and most useful type of suggestion structure. Positive suggestions are supportive and encouraging and are phrased in such a way as to give clients the idea that they can experience or accomplish something desirable. The generic structure for a positive suggestion is, "You can do X." (You'll come to recognize this as a permissive suggestion as well.) Since words call to mind the experiences that the words as symbols of experience represent, positive suggestions are phrased

Table 15.1
Suggestion Structures and Styles: Generic Forms

Suggestion/Style	Example
Direct style	"You can do (experience) X."
Indirect style	"I knew someone who experienced (did) X."
Authoritarian suggestion	"You will do X."
Permissive style	"You can allow yourself to do X."
Positive suggestion	"You can do X."
Negative suggestion	"You cannot do X."
Content suggestion	"You can experience this specific (e.g., sensation, memory)."
Process suggestion	"You can have a specific experience."
Posthypnotic suggestion	"Later, when you are in situation A, you can do X."

to create desired responses. The following suggestions are structured in both positive and permissive ways:

- You can feel more comfortable with each breath you inhale. (Deepening)
- You can remember a time when you felt very proud of yourself. (Age regression)
- You are able to discover inner strengths you didn't realize you had. (Resource building)
- You can notice how good it feels to relax. (Deepening)
- You may notice a soothing feeling of warmth in your hands. (Sensory alteration)

These examples are positive suggestions to clients about things they can experience. These suggestions are meant to be empowering, creating positive possibilities for them without demanding anything specific to resist. Amplifying what's possible, meaningful, and helpful is the foundation of positive suggestions.

Negative Suggestions

Negative suggestions employ a sort of reverse psychology approach when used skillfully. Negative suggestions may be used to obtain a response by suggesting the person *not* respond in the desired way. The generic structure for a negative suggestion is, "You cannot (or must not) do X." By telling individuals what not to do, they still have to process and interpret what you say, and the various subjective associations inevitably surface as they do so.

The following are examples of negative suggestions. Notice what your internal experience is as you slowly read each of them:

- Do not think of your favorite color.
- Do not allow yourself to wonder what time it is.

- I would suggest that you not notice that sensation in your leg.
- You shouldn't be thinking about your high school sweetheart right now.
- Please try not to notice which of your friends is the most materialistic.

Did you find yourself doing what was suggested that you not do? If so, why? If you were able to avoid doing what you were instructed to, how did you accomplish this? Did you have to actively distract yourself with some other thoughts? Would clients be able to prevent themselves from following the suggestion if they didn't know about negative suggestions?

All too often, unfortunately, negative suggestions are employed naïvely and accidentally, generating an unwanted response that may leave the practitioner wondering what went wrong. If a clinician says with great sincerity and the positive intention of comforting the client, "Don't worry about it, there's nothing you can do about it, so just put it out of your mind," the client is most likely to still worry and think about "it." If a lawyer says to a jury, "Don't think about the horrible crime my client committed. Instead judge him only as a scared, confused person," it is a safe bet the jury has just recalled all the gory details of the crime and the feelings they have about it. Accidental outcomes as a result of nonselective use of negative suggestions can undo in a half-sentence what might have taken considerably longer to accomplish. Use them carefully.

Many experts hold the opinion that the unconscious is unable to respond to negative suggestions. Based on your experience of the aforementioned examples of negative suggestions, do you agree? If I ask you not to think of the taste of pizza, don't you first have to think of it before erasing it from your mind in whatever way you might do so? Your unconscious responds to a negative with a positive. How might negative suggestions be used deliberately to facilitate the experience of hypnosis? By suggesting to clients that they not do the things you actually want them to do (assuming the appropriate client and situational variables warrant this approach), you pave the way for them to respond in a way that can be defined only as cooperative. For example, if I say to my client, "Don't let your breathing slow down as you listen to me, or else your muscles might relax," the client can now respond by either letting his breathing slow down and muscles relax (i.e., positive signs of the beginning of hypnosis) or by continuing in the current state, essentially complying with the literal suggestion (i.e., a cooperative response). Thus, either response is cooperative, directly or indirectly.

Other examples may include negative suggestions such as the following:

- Don't even consider the possibility that there might be a positive way to solve this problem.
- There's no reason you should even think about how good it will feel to get this behind you.
- Don't sit in a comfortable position if you can help it. I'd prefer that you don't discover that you can relax here, at least not yet.

Negative suggestions are a way of "short-circuiting" resistances, occupying the client with negativity while asking for positive responses indirectly. For clients who are characteristically negative, this may be a way of meeting them in their frame of reference. Clients' typical response is to gradually ignore the negative and respond more to the implicit positive suggestion.

Direct Suggestions

Direct suggestions deal with the problem at hand or the specific response desired overtly and clearly. Direct suggestions provide specific directions to clients regarding how to respond. Consequently, they are not known for their subtlety. The generic structure for a direct suggestion is, "You can do X." The form of a direct suggestion can vary within this generic structure, depending on your specific word choice.

To initiate the hypnosis session, the clinician will typically suggest that clients close their eyes. If the clinician chooses a direct approach to eye closure, he or she might offer any of the following direct suggestions:

- Close your eyes.
- Please close your eyes.
- You can close your eyes.
- Let your eyes close.
- I would like you to close your eyes now.

Each of these suggestions directly relates to obtaining eye closure from the client as a specific response. There is no mistaking what the clinician wants the clients to do. The same direct suggestion structures, by changing their content (i.e., associated details) might be used to suggest virtually any desired response:

- You can go back in your memory and remember when you went to your first school dance. (Age regression)
- I want you to let your arm lift effortlessly and become weightless. (Sensory alteration and arm levitation)
- You will be able to make your hand numb in the next few seconds. (Analgesia)
- Experience each minute as if it were an hour. (Time distortion)

The desired response in each of these examples is apparent because the suggestions directly ask for it. Additional direct suggestions may then be offered to provide a concrete means, a strategy, for accomplishing the suggested response:

- Imagine you are in a time machine that is taking you back to your first school dance.
- You can feel that your arm is tied to a large helium balloon allowing it to float.

- Remember how your hand tingles when you get a shot of Novocain? You can have that same sensation of numbness in your hand now.
- Time passes so slowly when you are waiting for something special, and you can notice now how slowly the hands of time move.

Many clinicians employ direct suggestions almost exclusively. For some, it was simply how they were trained so it's what they're most comfortable with. Some have difficulty evolving the flexibility it takes to vary their communication style even though they perceive it might be beneficial to do so. Others haven't seen the need to evolve any other style besides a direct one because they haven't seen any evidence for other styles being any more effective. The issue of one suggestion technique being "better" than another is one of the lingering controversies in the field, and I address it directly later in this section.

Training courses and books that offer standardized one-size-fits-all scripts for use with general problems are typically direct in their approach. They employ suggestions that represent a frontal assault on the presenting problem. For example, if a client presents the complaint of wanting to lose weight, a direct approach might offer suggestions such as:

> You want to lose weight, and you will lose weight.… You will lose weight seemingly effortlessly because you will find yourself becoming choosier about what you eat and when you eat.… Whenever you reach for either a fattening or unnecessary food you will instantly see the detailed image in your mind of yourself weighing your ideal weight, and it will feel so good and so motivating to you that you will find it much easier to choose not to overeat.… You would rather lose weight than eat fattening foods.… You will feel so good about yourself in this process that losing weight becomes easier and easier, and you'll find yourself being satisfied with less and less food.… You'll feel extra energy as you lose weight and so you will also want to exercise more just to use your extra energy to get leaner and stronger.

This kind of direct approach may work with some people, perhaps some highly hypnotizable, deeply motivated ones. It's not that such direct suggestions are bad, wrong, or destined to fail. In fact, for individuals who want to lose weight they will have to do as suggested, that is, eat less and exercise more. But that's the equivalent of telling a depressed person to "Cheer up!" It's correct, but not particularly effective. For most people, supportive and not merely demanding suggestions are required as well as a more highly individualized approach acknowledging their uniqueness. Telling clients bluntly what to do does not show much clinical skill, nor does it show much respect for their intelligence and creativity. People typically already know what to do; they just don't have access to the resources that would allow them to do it. Realistically, do you think there's an overweight person out there who doesn't already know to eat less and exercise more? Finally, such approaches don't involve as much of the person in the therapy process as a more collaborative

effort would. Thus, direct suggestions can be greatly helpful, but familiarity and skill with both direct and indirect approaches are essential to the development of a broader, more flexible practice of clinical hypnosis.

The advantages of direct suggestions include the following:

1. Their direct relevance to the matters at hand, potentially easing concerns in clients about your ability to deal directly with their problems
2. Their ability to keep clients' goals well defined and in sight
3. Their direct involvement of clients in the hypnotic process in an active way
4. Their ability to serve as a model for the resolution of this and any future problems that arise through the development of a deliberate problem-solving strategy

The disadvantages of direct suggestions include the following:

1. Their overreliance on a conscious willingness to follow suggestions, possibly making less use of unconscious resources
2. Their greater likelihood of engendering resistance in clients by dealing so directly and even bluntly with their problems, potentially a threatening experience for some
3. Their defining clients' role primarily as one of mere compliance rather than an as active participant in the therapy

Appreciating the advantages and disadvantages of the use of direct suggestions is necessary to make an informed decision as to when their use will most likely result in a successful hypnotic experience (Lynn, Neufeld, & Mare, 1993; Lynn, Neufeld, & Matyi, 1987; Yapko, 1983).

Indirect Suggestions

Indirect suggestions relate to the problem at hand or the specific desired response in a covert or at least less obvious and unobtrusive way. They can be quite subtle and thereby escape clients' full awareness and analysis. Such suggestions do not relate directly to individuals' conscious experience. Rather, they are only indirectly related and thus require that clients find relevance and make meaning of them. The generic structure of an indirect suggestion is, "I knew someone who experienced (or did) X." By talking about someone else or some other situation, clients' response is invited through an indirect means. Use of indirect suggestions can have them wondering at a conscious level what you are talking about. They may simply occupy (amuse, entertain, fascinate) persons at a conscious level while at the same time unconscious associations are generated that can pave the way for change to take place.

Consider as an easy example a child's fairy tale. When you tell a child the story of *The Three Little Pigs*, the child can easily be entertained and fascinated

by the drama of the story and by the playful exchange when you both "huff and puff and blow the house down." But beneath the entertaining content of the story (i.e., the characters and the things they say to each other), there is a deeper message you hope to impart: the importance of planning, discipline, and hard work to move through life choosing substance, represented by a house made methodically of brick, over "flash," symbolized by flimsy homes made quickly of only wood or straw. People can transmit and receive deeper messages of substance through such indirect paths as stories. We don't have to experience something directly to be influenced by it. Clinically speaking, every time someone provides you with a successful case example, you may be interested in and become absorbed in the details of the case, but the inescapable yet indirect message to you is, "When you see this type of client, you can use this kind of an approach."

Indirect suggestions can take numerous forms, including storytelling, analogies, jokes, puns, homework assignments, role modeling, and disguised and embedded suggestions. Any communication device that causes or requires clients to respond without directly telling or asking them to do so involves some degree of indirect suggestion.

The use of indirect suggestion is a focal point of study in the *utilization approach* to hypnosis, largely due to the many creative ways they were used by Milton H. Erickson. Erickson was widely acknowledged for his skill and creativity in formulating successful interventions, often with seemingly "impossible" clients. When you read his fascinating and unusual cases, many of which he described in his own words in the book *A Teaching Seminar With Milton H. Erickson, M.D.* (Zeig, 1980b), many of his ingenius hypnotic and strategic interventions seemed to have absolutely no relationship to the presenting complaint, so indirect were they. Yet his therapeutic effectiveness with hypnosis and indirect suggestions has inspired intensive analysis of his methods and forced an appreciation for the merits of indirect approaches in the field when others succeed similarly using his methods (Lankton, 2010; Lankton & Matthews, 2010). Thus, an advanced study of clinical hypnosis is literally impossible without studying Erickson's work directly as well as the writings about his methods by his many students and colleagues (e.g., Erickson & Rossi, 1979, 1981; Erickson, Rossi, & Rossi, 1976; Gilligan, 1987; Haley, 1973, 1985; Lankton & Lankton, 1983; O'Hanlon, 1987; O'Hanlon & Hexum, 1990; Rosen, 1982; Rossi, 1980).

To contrast direct and indirect suggestions, you can refer to the previous section's examples for obtaining eye closure through direct suggestions. If you suspect, on the basis of feedback from clients, that you would be more likely to get eye closure through indirect methods, you might offer any of the following suggestions:

- Responsive clients usually begin the hypnotic experience by closing their eyes.
- Can you allow your eyes to close?

- Many of my clients like to sit there with their eyes closed.
- Isn't it nice not to have to listen with your eyes open?
- I wonder what you will think of that will allow you to comfortably *close your eyes.*

Each of these examples seeks eye closure as a specific response, but it has never been asked for directly. The statements are general ones that clients must respond to in some way since even no response is a response. The clinician can learn quite a bit about how they think and respond from the way they relate to such suggestions. For example, do they take initiative in responding or simply wait to be told exactly what to do?

One pattern of indirection may take the form of simply describing others' experiences, allowing clients to choose a similar response or else generate an independent one. Another indirect pattern is to have clients become aware of routine, everyday experiences where the desired response is a natural event. As they become focused on and associated to such a situation, they can begin to reexperience it as the responses associated with the past experience become part of the current experience. For example, if you were to think of a time when you felt very romantic and loving toward someone and really spent time recalling the details of that experience, those same feelings are likely to arise automatically now through your recall, a phenomenon called an ideoaffective response. Thus, instead of demanding the specific response of creating those feelings now in a direct way, I can suggest them less directly by simply describing a context where such feelings are likely to naturally occur.

As with eye closure, indirect suggestions can be varied in content to obtain virtually any response:

- A close friend of mine has a daughter who went to her first school dance, and I don't know if you can remember yours, but it sure was an exciting time for her. (Age regression)
- When you were in grade school you had to raise your hand slowly when you wanted to say something important, and sometimes it would raise as if it were weightless and you didn't even realize it. (Sensory alteration and arm levitation)
- Can you imagine what it's like to have a barehanded snowball fight and have so much fun making and throwing snowballs you forgot to notice you weren't even wearing gloves? (Analgesia)
- Time is so difficult to keep track of, and after all a minute can seem like 5 or 10 minutes sometimes; you've had that experience, where you can get so wrapped up in your thoughts that only one minute can seem so much longer. (Time distortion)

In each of these examples, clients' immediate experience is seemingly less the focal point than someone else's, or the suggestion seems so general as to be impersonal and therefore not requiring a direct response. It is up to clients

to adapt themselves in their own unique way to the possibilities for certain responses raised by the clinician's suggestion. In this way, direct commands for obedience are avoided, and clients' creative ability to form an individualized response is tapped. How they find a way to accomplish the possible response suggested can be as varied and creative as are people.

The advantages of the indirect approaches include the following:

1. Their greater utilization of unconscious resources on clients' behalf
2. Their greater distance between the suggestion and its intended target emotion or behavior, potentially reducing the need for resistant defenses
3. Their permissiveness in encouraging the client to interpret the suggestions in whatever way might be deemed useful, demonstrating a greater respect for clients by accepting their responses as valid
4. Their defining clients' role in the treatment process as active rather than merely compliant

The disadvantages of the indirect style include the following:

1. Clients' possible fear or anxiety that the clinician is either unable or unwilling to deal directly with their problem, and "if the therapist can't, how can *I*?"
2. The clinician becoming viewed as evasive or incompetent by seemingly being irrelevant in "talking around" issues, or clients feeling manipulated and even cheated
3. Clients' unconscious responses allowing for alleviation of the problem but possibly leaving them consciously wondering how the change occurred, as if therapy was done "to" rather than "with" them
4. The problem being solved but not leaving clients with a knowledge of and access to effective and self-managed patterns for solving future problems

As with direct suggestions, appreciating the advantages and disadvantages of using indirect suggestions gives you an ability to make sensible choices about their applications (Lynn et al., 1987, 1993; Yapko, 1983).

CHOOSING A STYLE: ARE DIRECT OR INDIRECT SUGGESTIONS BETTER?

One of the ongoing debates within the field concerns the issue of which form of suggestion—direct or indirect—is clinically superior. Numerous studies have attempted to answer the question, and, as one might expect, they differ in their conclusions (Barber, 1980; Fricton & Roth, 1985; Groth-Marnat & Mitchell, 1998; Hayes & Gifford, 1997; Lynn et al., 1993; Yapko, 1983). Such research misses an obvious point: no suggestion is inherently worth much; a suggestion becomes meaningful only when clients accept, integrate, and respond meaningfully to it. Thus, generalizations about the superiority of one form of suggestion over

another may, at best, be academically interesting, but they have little bearing on what individual clients will respond well to. Thus, if you know how to be only direct, you will be at a distinct disadvantage when you encounter clients who will respond better to less direct approaches. The most sensible goal is to be fluent in all suggestive approaches and to vary them as circumstances warrant.

For many experts in the field, as we saw in the previous chapter, the recommendation on this issue is to formally assess hypnotizability and to use clients' profile (low, medium, or high hypnotizable) to determine whether you should even attempt hypnosis. The more hypnotizable the person, they believe, the more direct you can be in your methods. Based on his observations of Erickson's work, Jeffrey Zeig (1980b) suggested a basic guideline to determine which style to use: "… the amount of indirection used is directly proportional to the amount of perceived resistance" (p. 13). In other words, the greater the degree of clients' unwillingness to follow directives, the more indirectly the suggestions should be offered.

It seems there are few, if any, absolute "right" or "wrong" ways to structure therapeutic interventions. Rather, there are ways that are effective and ineffective with specific clients, and it grows ever more obvious from diverse yet successful interventions that there are many "right" ways. As with all the hypnotic communication patterns presented in this book, what you do at any given moment will rely on the feedback you get from clients. After all, they are the determinant of what works. You can feel much more secure in your abilities to relate to a wider range of people if you have both direct and indirect approaches available in your repertoire.

Content Suggestions

Content suggestions contain highly specific details describing the feelings, memories, thoughts, or fantasies clients are to experience during hypnosis. The generic content suggestion structure is, "You can experience this specific _____ [e.g., sensation, memory]." Providing details that describe many dimensions of the suggested experience can have the desired effect of assisting clients to have the experience more completely, therefore with a greater degree of absorption and clinical usefulness.

Examples of content suggestions include:

- Think of a red rose with soft, velvet petals you can lightly brush against your nose as you inhale its gentle, sweet fragrance.
- Imagine being at the beach on a bright, clear day, feeling the sun warming your skin, smelling the salt in the ocean breeze, and hearing the lapping of the waves upon the shore.
- Can you remember how pleasing it is to bite into a juicy, wet orange, how your mouth waters, how the juice feels as it runs all over your fingers, and how tart it tastes?

Each of these examples provides specific details about exactly what you are to experience in thinking of a rose, the beach, and an orange. Perhaps those details allowed you to have the suggested experience more fully, in which case the details were helpful to you. However, these examples can also illustrate a potential hazard in using content-filled suggestions, namely, that the details I directed you to notice may not be the ones you would have chosen to focus on. Or, at their worst, they may even have been details that negated the experience for you. If, for example, when I said, "Imagine the beach," you recalled a negative experience you had at the beach, or if you have never experienced being at a beach at any time in your life, then the details will lead you to a negative memory or perplex you as to what I'm getting at. Either way is disruptive. The potential problem with content suggestions is simply this: the more details you provide, the greater the probability that something you say will contradict your clients' experience. The end result is that they may sense that you are not really "with" them and will be less likely to benefit from the experience.

On the other hand, if you offer content to clients and the details you suggest actually fit with their experience, the details will enhance the experience. One way to increase the fit of content suggestions is to notice the many cues the clients continually provide through natural conversation about their experience. This includes such things as style of language, sensory-based terms they spontaneously use in speaking, and details they provide of experiences you can provide as feedback later during hypnosis. Another possibility is to do a general hypnosis session and ask for direct feedback about which suggestions helped deepen their involvement in the experience and which seemed less effective. Yet another solution is to use process suggestions instead of content suggestions, discussed in the next section.

Process Suggestions

In contrast to the details provided in content suggestions, process suggestions provide minimal details at most, encouraging clients to provide their own instead. The generic structure for a process suggestion is, "You can have a specific experience (or awareness)." However, what the "specific" experience or awareness should be is not actually specified. In response to the deliberate ambiguity in the suggestion, clients project their own personal experiences and frame of reference into the suggestion to make meaning of it. Consequently, process suggestions are less likely to contradict the experience of clients since the details involved are their own. For example, if I would like clients to imagine being in a relaxing place, instead of me choosing the beach as a specific place to focus on and then providing lots of details (content suggestions) about what it's like to be at the beach, I can simply suggest to them that they imagine being somewhere relaxing. I don't say where that place

might be, so they can choose the specific place and which particular details of that place to focus on. Process suggestions are so general in nature that clients can project personal meaning into them and then relate to them in their own individual way.

If you read horoscopes, you have a common example of process suggestions. The observations and predictions are so nonspecific that they can apply to virtually anyone. For example:

> You are a person who likes to be with those people you care about, but sometimes you prefer to just be left alone. Sometimes you get very frustrated with events in your life, and even lose your temper on occasion. You would like more people to appreciate you, and you often think you deserve to make more money than you do. Sometimes you think terrible things about people you really do care about and then feel guilty about it.

I think this represents most of the human beings on the planet, but did you find yourself silently agreeing and wondering, "How did he know that?" Process instructions give clients the opportunity to use their own experience and details in the process and therefore to make what seems, at first glance, to be too general to be effective appear to be a highly individualized approach. As you will discover in your use of process suggestions, people take their projections very seriously. Even for something as silly as astrology, there are people who invest themselves in horoscopes as daily guides to action. People get even more serious when they project themselves into the big questions of life: Why are we here? What's the meaning of life? What happens after we die?

The following are examples of process suggestions:

- You can have a particular memory from childhood, one that you haven't thought about in a long, long time. (Age regression)
- You will notice a certain pleasant sensation in your body as you sit there comfortably. (Kinesthetic awareness)
- You may become aware of a specific sound in the room. (Auditory awareness)
- Can you remember that special time when you felt so good about yourself? (Age regression)

None of these suggestions specifies anything—that is, they do not say which specific memory, sensation, sound, or event clients are supposed to experience. They choose that aspect of the experience when they project a response to the suggestion. Notice, though, the use of qualifiers such as *particular, certain, specific*, and *special* in process suggestions. These can be employed to have clients sift all of their experiences down to one particular one to focus upon. Which one they choose is the product of an interaction between conscious and unconscious choices. Typically, clients wonder how you knew

what they were experiencing, not realizing how general your suggestion was because of how specific it seemed. The use of process suggestions is often harder to master because of the "groping-in-the-dark" aspect to them. But their ability to sidestep contradictions between the details the clinician provides and clients' actual experience makes them imperative to learn to use well.

Process suggestions are especially valuable in doing group hypnosis processes, in which the opportunity to carefully watch individuals' responses to content suggestions is virtually impossible. Using process suggestions of a general yet specific-sounding nature allows each person in the group to have an entirely different experience in response to a single set of suggestions. Trying to make a group of people share a common, detailed experience is a setup for failure. Thus, through process suggestions the diversity among people is acknowledged and encouraged.

The content versus process paradigm can be viewed in yet another way: dealing with the details contained in the structure of an experience or with the structure itself. Content-oriented therapies deal with details of the problem, whereas process-oriented therapies focus on the problem's structure. For example, many people seek out a certain type of person in a romantic relationship, one who fits some measure of desirability that may or may not be a conscious criterion. So, if a person has a succession of intimate relationships with someone tall and dark-haired, who is a fashionable dresser, tight-lipped about feelings, and domineering, and each time the relationship ends in disaster, then what can be concluded? People have patterns that guide their behavior, and these are generally unconscious. In the current example, the content is each specific person in the succession of partners. The names and faces change but not the structure of how a relationship partner is chosen, that is, the type of person in the pattern. The content approach to therapy might deal with the reasons this particular relationship isn't working out, while a process approach might consider the structure of the pattern for how partners are chosen. By altering the structure of the pattern of selection, a change in the details (content) must naturally follow.

Using process or content suggestions is simply another choice point for the clinician in formulating an intervention. Shifting spontaneously from one suggestion structure to another is an easy thing to do, so the decision about which structure to use is by no means a final one, a "sink-or-swim" proposition. If what you are doing isn't getting the desired response, then flexibly making a midstream shift in your approach is a good idea.

Authoritarian Suggestions

The authoritarian style is a domineering one in which the clinician uses the power of his or her position to literally command clients to respond in a particular way. The generic structure for an authoritarian style is, "You will do X." Authority and power are the key variables the clinician relies on,

and the response from "good" clients is compliance. In the authoritarian approach, a lack of compliance is evidence of "resistance" and, unfortunately, is reflexively viewed as a client shortcoming. Literature advocating authoritarian styles as a modus operandi typically suggests first confronting clients about their resistance to the procedures and then attempting to eliminate it by identifying its source and means of resolution. You may anticipate how easily this type of confrontational approach can initiate a "power struggle."

Authoritarian approaches involve offering suggestions in the form of commands. The following suggestions are structured in an authoritarian mode:

- Close your eyes when I count to three. (Eye closure)
- When I snap my fingers, you will be 6 years old. (Age regression)
- When I touch your shoulder, you will go into deep hypnosis. (Deepening)
- You will find it impossible to bend your arm. (Catalepsy)
- You will not remember anything from this experience. (Amnesia)

Directing individuals to respond in a specific way that minimizes personal choice does not show much respect for their needs or wants. Thus, a strictly authoritarian approach should generally be used sparingly. There are times, though, when such an approach is not only viable but also even desirable: when a vulnerable and confused patient needs a clinician who is clearly in charge and decisive, and when the good quality of the therapeutic alliance between you and the client makes what you have to say far more important than how diplomatically you say it.

Permissive Suggestions

At the other end of the continuum is the "permissive" style, characterized by its emphasis on allowing clients to become aware of possibilities for meaningful responses rather than making demands for such responses. The generic structure for the permissive suggestion is, "You can do X." The clinician offers suggestions of what clients may experience if they so choose. The sensibility of a permissive approach is in knowing you can't make clients respond (e.g., relax or focus). You can simply suggest possibilities in such a way that they, hopefully, choose to avail themselves of those possibilities. Any response is deemed an adequate or usable one by the clinician, respectful of clients' choice. In this way, "resistance" is much less debilitating a factor, since whatever response they generate is deemed acceptable.

Permissive suggestions are intended to raise the possibility of a response, and the following examples may illustrate the point:

- You can allow your eyes to close, if you would like. (Eye closure)
- You may choose to uncross your legs. (Postural shift)
- You might be willing to let yourself relax even more deeply. (Deepening)

- It's possible to experience your body differently. (Perceptual shift)
- Perhaps you can remember a time when you felt comfortable. (Age regression)

In these examples, the clinician is simply saying, in one form or another, that clients can have an experience if they permit it. Clients' response in any direction is thus a choice and must be respected as such. Such acceptance by the clinician can add to the rapport by demonstrating a respect for clients as people capable of making their own choices. It may be implicit thus far, but can now be stated explicitly, that when clients' choices are deemed counterproductive to your treatment plan your strategy needs to be revised.

In sum, there are those who want to be told what to do and will follow instructions to the letter, and there are those who refuse to follow anyone's lead and will even go out of their way to reject others' input simply because they resist being "controlled." If someone is willing to follow directives obediently, an authoritarian approach may be successfully employed. With most people, however, it will tend to set up power struggles. The permissive approach is good for creating possibilities in people who like to have a large measure of control in their lives by making their own decisions but may frustrate people who want to be told in explicit terms exactly what to do in a step-by-step fashion. Both authoritarian and permissive styles have their place in doing hypnosis, and as with all forms of suggestion it will enhance your effectiveness when you familiarize yourself with their usage.

Posthypnotic Suggestions

Posthypnotic suggestions are those given to clients during hypnosis that encourage particular thoughts, behaviors, and feelings they are to have later, following the hypnosis (hence, posthypnotic), in some other context. Posthypnotic suggestions have the generic structure, "Later, when you're in situation A, you'll be able to experience (do) X." They are considered a standard part of nearly every therapy session since you will almost always want clients to take something away from the session that they can use elsewhere in the course of daily living. Posthypnotic suggestions make it possible for people to carry over into the desired context whatever new associations they have acquired during hypnosis.

Posthypnotic suggestions are a necessary part of the therapeutic process if clients are to carry new possibilities into future experiences. Without them, the learnings acquired during hypnosis will most probably be limited to the session itself. The reason for this is that hypnotic responses are generally "trance state-specific," meaning they are tied to the immediacy of the hypnotic experience, operating only within the boundaries of that experience. Posthypnotic suggestions permit the learnings acquired during hypnosis to cross internal boundaries and become available in other locations and frames of mind. If

clients can only have the desired experience, such as pain relief, during hypnosis in your office, then the value of hypnosis is limited. Its value increases exponentially when new resources are extended across contexts. Posthypnotic suggestions facilitate that possibility.

The following are examples of posthypnotic suggestions:

- When you come out of hypnosis in a few moments, you can enjoy the feeling that you rested to a more satisfying degree than you have in a long, long time.
- When you begin to take your examination next week, you can close your eyes for a moment that can seem much longer and take a deep breath, and you can notice all the anxiety leaving you as you exhale.
- After you go home tonight, you'll have a certain memory that will make you laugh, and it'll feel really good to let off some steam in such an enjoyable way.
- When you find yourself in the next argument with your boss, the feeling of comfort that she can disagree with you but still appreciate you will soothe you enough to handle the discussion calmly in a way you feel proud of.
- In our future sessions you can experience hypnosis even more deeply and rapidly.

Each of these examples suggests a behavior or feeling the client is to experience in some future time and place to be based on the suggestions given to him or her during hypnosis. Most interestingly, some clients may have no conscious memory for the origin of the suggestion, called posthypnotic amnesia, but act on it nonetheless.

SPECIALIZED SUGGESTIONS

While the suggestion structures and styles described throughout this chapter thus far represent the core components of hypnotic suggestion, numerous other more specialized forms of suggestion may be derived from the core components. Most of these specialized suggestion forms were first conceived of and described by Erickson and his student and collaborator Ernest Rossi and are contained in the books that involve Erickson training Rossi in hypnosis (see Erickson et al., 1976; Erickson & Rossi, 1979, 1981) as well as the lectures and papers of Erickson (Erickson, 1983, 1985; Rossi, 1980). These specialized forms of suggestion are described briefly in this section.

Accessing Questions

Questions that encourage clients to respond experientially rather than verbally are known as accessing questions. More than rhetorical questions,

accessing questions focus clients on particular aspects of their experience, which are amplified simply through the way the question was asked. In other words, the question suggests a response. For example, "Can you recall how very soothing and relaxing it is to lie in the warm sun and feel it warming your skin?" In the clinical domain, accessing questions are used to enhance treatment responsiveness.

Ambiguous Suggestions

You can deliberately embed ambiguity in a suggestion to encourage clients' projections, related to but slightly different from the nonspecific "process" suggestion. The ambiguity may surround the desired action on the part of clients or the meaning of the suggestion. For example, suggesting, "One can be quite iron-willed and hardheaded in such matters," leaves it open to interpretation as to whether the clinician is praising perseverance or criticizing stubbornness.

Apposition of Opposites

Offering suggestions that create distinct polarities of experience within clients is making use of the apposition of opposites. For example, "As your left hand becomes pleasantly cold and numb, you'll notice your right hand becoming comfortably warm and responsive." The increased awareness of such marked differences can lead clients to believe, "Hey, I'm doing it!"—a positive response that reinforces further responsiveness.

Bind of Comparable Alternatives

Providing clients with a bind of comparable alternatives, a classic double-bind, creates a "forced choice" situation for them in which both choices lead to an equally desirable outcome: "Would you enjoy a deep and satisfying hypnotic experience while you're sitting in this chair or in that chair?" For as long as they noncritically accept the bind and respond within the parameters of the suggestion, the bind can be effective. If, in another example, you say to a child, "Would you prefer to clean your room now or in an hour?" and the child says, "Neither!" the bind is useless.

Confusional Suggestions

Suggestions deliberately constructed to disorient or confuse clients to build responsiveness, to overload an overly intellectual demeanor, or to facilitate dissociation are known as confusional. Confusional suggestions are one of the most advanced suggestion structures to employ because they aren't linear and logical, they generate uncertainty and even anxiety rather than comfort

and clarity, and they require greater concentration on the part of the clinician to keep track of where the process is going. But they are valuable in interrupting ongoing client patterns of thought and perception, perhaps paving the way for new possibilities. More is said about methods employing confusion in later chapters.

Covering All Possibilities

An effective way to enhance responsiveness in clients is to include any and all possible responses in your suggestion, thereby defining any specific response as a useful, cooperative one. For example, "You may find yourself recalling an important memory … perhaps one from quite early in your life … perhaps a memory that is very recent … or perhaps one from somewhere in between a long time ago and very recent times.…" Well, what other possibilities are there? Any memory will be from the past, obviously, whether recent, intermediate, or distant. Thus, any memory they retrieve is in line with the suggestion and can thus be framed as a cooperative response.

Implied Directives

An indirect way to encourage a response is through the use of implied directives. The first part of the suggestion structure is the indirect suggestion to do something from which the second half of the suggestion then directly suggests a response. For example, "When you experience your hand lifting in just a moment (indirect suggestion), you will notice that it feels very, very light" (direct suggestion). The lifting of the hand is implied but not asked for directly.

Interspersal of Suggestions

The frequent repetition of key words or phrases within an ongoing flow of suggestions is called an interspersal approach. You can use an interspersal of suggestions to deepen the hypnotic experience, facilitate the experience of a specific hypnotic phenomenon, "seed" (implant) ideas for future reference, or simply to reiterate an important point. For example, "A deep thinker, that is, one who thinks deeply, can evolve a deeper understanding of the complexities of suggestions and perhaps an even deeper understanding of himself or herself in gaining depth of knowledge about suggestion" (deepening technique).

Metaphors

Metaphors have come to mean the use of stories in the literature of clinical hypnosis. Metaphors are considered one of the most powerful yet gentle

means for communicating relevant information to clients using the vehicle of the story to bring important points to life. The art of creating and telling effective stories in hypnosis for therapeutic purposes deserves special attention and so will be addressed in greater detail in later chapters.

Paradoxical Suggestions

Paradoxical suggestions contain what seem to be, at first glance, incompatible or even contradictory components contained within the same overall suggestion. For example, "You can take all the time in the world … in the next minute … to complete your inner work of integrating your new understanding."

Presuppositions

A presupposition assumes the suggested response will happen. It's not a question of whether the response will occur; it's simply a matter of when. For example, "How pleasantly surprised will you be when you discover that you understand presuppositions?"

Puns

The use of humor as a reframing device can be a valuable way of engaging clients in the process while simultaneously establishing a friendly and warm emotional association to the experience of hypnosis. For example, "Some people like to do hypnosis with a slow and rhythmic style of delivering suggestions … even pacing suggestions to the rhythm of the client's breathing … but you know and I know that the rhythm method is not very reliable.…" Can hypnotized persons appreciate humor and even smile or laugh during hypnosis without diminishing the value of the experience? Yes. In fact, the positive associations of humor to your session may make your suggestions even more effective.

Truisms

A truism is a commonsense statement that appears to be so obviously true and self-evident that it is virtually impossible to reject. For example, "Every person is unique (truism), we all know that …, which is why you can experience deep hypnosis in your own unique way." Truisms are generally used to build an acceptance of the suggestions that follows them as individuals evolve an agreeable mind-set. Building receptivity in clients in this way is called establishing a *response set*. The response set is critically important, for without an easy acceptance of your suggestions the potential for therapy to be helpful is severely restricted. Thus, the response set is considered in greater detail later.

CONCLUSION

Words can be viewed as conditioned stimuli that can come to evoke the same or similar responses as the objects or concepts they represent. Therefore, words have to be chosen carefully, as does the manner in which they are spoken. This chapter has detailed the different styles and structures underlying diverse hypnotic communications. They each have value with different people at different times, encouraging the development of a comfortable fluency with their use.

FOR DISCUSSION

1. When a friend recommends a movie or restaurant to you, what factors determine whether or not you'll follow the recommendation?
2. Why do people reject suggestions that are clearly in their best interest?
3. What differences can you identify between people who like to be told what to do and those who don't?
4. What changes have you made on the basis of insight? What changes have you made for no apparent reason? What do you think about the role of insight in the process of change?
5. How do you feel when someone tells you how you feel? How is the feeling different when he or she is right than when he or she is wrong?

THINGS TO DO

1. Make a list of the most common hypnotic suggestions (e.g., "Relax," Sit comfortably," "Close your eyes," "Breathe at a comfortable rate") and write five suggestions in each style and structure to get that idea across. This is one of the best exercises there is to develop skill and flexibility in suggestion formation.
2. In class, have each student make up an imaginary product, and have each attempt to sell it to the rest of the class. Which sales pitches were best and why? Which were least effective and why?
3. Read the horoscopes daily and identify the process suggestions employed. What do you discover about the generality of language? What sort of person (specify his or her cognitive style) would think horoscopes have merit?

CHAPTER 16

HELPFUL HINTS FOR CONDUCTING CLINICAL HYPNOSIS SESSIONS

In the previous chapter, I described general styles and structures for forming suggestions. In this chapter, some general guidelines for your choice of particular words and phrases within those styles and structures will be provided. These guidelines are intended to help you form suggestions that are more likely to be accepted by the individuals you are working with.

These guidelines are, for the most part, communication skills based on common sense. While these guidelines generally hold true for most hypnotic processes, you should, of course, be aware that each principle has exceptions that may be even more useful to apply with particular clients. Therefore, a brief discussion of each general principle is provided to encourage you to think critically about whether and how it might apply in a session. By thinking of particular contexts in which the principle might not apply, and thinking of an alternative that might be more effective, you will increase your range of choices in responding skillfully to your clients.

KEEP YOUR SUGGESTIONS SIMPLE AND EASY TO FOLLOW

Generally, the more complicated a set of suggestions or instructions you provide for individuals to follow, the more they must expend effort and rely on

conscious resources to help understand and respond to them. That's true both in and out of hypnosis. The more people must rely on conscious resources, the less they can respond experientially, partially defeating one of the primary reasons for doing hypnosis in the first place. Keeping your suggestions relatively simple allows clients to "go with the flow" of the process without having to critically—and therefore consciously—analyze, interpret, and judge the merits of your suggestions. It's too much work to try to follow complicated instructions, especially when they are trying to relax, focus, and get some help.

The exceptions to this guideline involve the use of specialized techniques whose value is derived from their complexity rather than from their simplicity. These advanced techniques include confusional suggestions and overload techniques in which confusing ideas and an overabundance of information are provided deliberately. These techniques involve placing an excessive burden on the conscious mind as it strives to make sense of it all, eventually taxing it to the point where it can no longer keep up. When clients eventually give up trying to follow, they essentially resign themselves to noncritically allowing the experience to unfold.

How, then, do you know whether your suggestions are too complex and working against your goals? Observe clients' responses. Every suggestion that lightens their experience of hypnosis and every undesirable response to your suggestions indicate that they may not be following you, which also means you may not have been following them as well as you might have. A more direct means for finding out how clients are doing is to simply ask them neutrally, directly or indirectly, for specific verbal and nonverbal feedback about their experience both during and again after the hypnosis session.

Keeping suggestions easy to follow isn't the same as being predictable and obvious about where you are going with the hypnotic process. If clients are able to guess where you're going and can too easily remain a step ahead of you, there is obviously considerable conscious analysis taking place, increasing the likelihood of reduced responsiveness. If you become aware that you may have lost them somewhere along the way, you can go back to an earlier point in the process where you sensed they were with you and go on from there, but obviously not in the same way. If you are as observant as you can possibly be during the process, you won't have to go back very far.

Keep in mind that only your clients can determine what they can and cannot follow. You may think your directives were easily understandable, but you're not the one following them—your clients are.

USE CLIENTS' LANGUAGE AS MUCH AS SENSIBLY POSSIBLE

One especially helpful tip is to use clients' language whenever possible. Words represent experience, and even though we may use a common language our

FRAME OF REFERENCE: JEFFREY K. ZEIG

Jeffrey K. Zeig (1947–) is founder and director of the Milton H. Erickson Foundation in Phoenix, Arizona. He is a superb clinician and teacher, routinely criss-crossing the globe as he lectures nationally and internationally to professionals. To date, he has taught in more than 40 countries. He is especially well known as a primary catalyst for bringing the pioneering work of Milton H. Erickson into the world spotlight. Dr. Zeig studied directly with Erickson for more than 6 years. Dr. Zeig's vision and organizational abilities have given rise to extraordinary meetings sponsored by the Erickson Foundation that are widely considered the best conferences for clinicians offered anywhere. He is the architect of the Evolution of Psychotherapy Conferences, regarded as the most important conferences in the history of psychotherapy. Each of these featured the true luminaries in the field of psychotherapy, all assembled in one place at one time, for what some have affectionately called the "Woodstocks of psychotherapy." He edited each of the proceedings from these meetings in impressive published volumes that are must-reads for clinicians. He organizes the Brief Therapy Conferences, the Couples Conferences, and the International Congresses on Ericksonian Approaches to Hypnosis and Psychotherapy.

In addition to being a psychologist and marriage and family therapist in private practice, Dr. Zeig is also the editor and author of 18 professional books and five monographs about Erickson and about psychotherapy, including *A Teaching Seminar with Milton H. Erickson, M.D.* (Zeig, 1980b), *Experiencing Erickson* (Zeig, 1985b), and *Milton H. Erickson* (Zeig & Munion, 1999).

On hypnosis and responsiveness: "One of the things that distinguishes hypnosis from other approaches is the idea of responsiveness, how people respond to the implication of communication, how people respond to innuendo.… Hypnosis

begins at the moment when people start to respond to the implications of communication."[2]

On the search for the biological signature of hypnosis: "Looking for physiological correlates of hypnosis is like 'looking for a hare that lives in the mind of a hunter.' That's a quote from R. D. Laing.… What's going on in hypnosis mentally is not one thing. It's a compilation of different elements that are put together over time, so hypnosis changes dynamically over time. So trying to find neurological correlates of hypnosis is basically impossible because hypnosis doesn't exist except in 'states,' as transient experiences."[2]

On his personal experience of Milton Erickson: "I vividly remember how emotionally touched I was by the experience of being with Erickson. On the second day of my visit, I watched him struggle to move himself from his wheelchair to his office chair. Then he started speaking to me through his obvious pain, intent on instructing me about how to be more effective as a person and therapist. I remember feeling powerfully moved that he would selflessly spend his limited energy to help me. No powerful figure I had met before had such a moving impact. There was something extraordinary about Erickson: Perhaps his profound effect was due to his acute sensitivity, respect for the individual, intensity, verve, uniqueness, and joie de vivre in the face of adversity. I saw him struggle to bring out the best in himself and it inspired me to want to do the same" (Zeig, 1985b, p. 167).

On the mission of the Milton H. Erickson Foundation: "The intention was to differentiate Ericksonian methods from other schools and then quickly integrate them into the mainstream of psychotherapy, which we accomplished. We did not want to establish Ericksonian therapy as a distinct school. Erickson's contributions have relevance to psychotherapy in general and now have been incorporated into other approaches, including cognitive behavioral therapy. Erickson's work advanced the field of psychotherapy; he was more than a pioneer in hypnosis."[1]

On how Erickson is widely perceived: "Erickson was sought after by some of the great minds of the 20th century, including Margaret Mead and Gregory Bateson. He was respected because of his genius, endeared because of his humanism. Now Erickson is widely acknowledged as one of psychotherapy's most innovative pioneers. Erickson was one of the most public therapists of his time, consistently showing what he did at a time when demonstrations of therapy for the professional public were not popular. His work is readily available for serious research and critique."[1]

On Erickson in retrospect: "I think Erickson was 'on the spot' in pioneering the doctrine of utilization; tailoring therapy to the uniqueness of the individual; using confusion and multilevel communication; and in harnessing what have become well understood and well researched social psychological principles of influence. But no amount of research will clarify the essential nature of hypnosis, just as no amount of research will clarify the essential nature of love. Erickson's artistry will not be lost because of research. Evolving research will shed light on the effectiveness

of his clinical work. Erickson was the consummate social psychologist studying how situational effects alter behavior. Recent mainstream psychological research studies on effects such as priming have demonstrated that Erickson was right in applying the analogous clinical method of 'seeding,' one of Erickson's favorites."[1]

On Erickson emphasizing personal development more than technique: "To my mind, there are two questions that we ask: One is how do we do hypnosis? The other is how will we be hypnotherapists? My bias is that more of the effect happens by virtue of the second question than the first.… Erickson never taught me technique. He never explained to me how to do an induction, [and] he never saw me do an induction. He never explained how to use a confusion technique, [and] he never saw me do a confusion technique. All of what Erickson did was experiential training, giving me tasks, stories, hypnosis, things he gave me to be the best Jeff Zeig. His focus was entirely on personal development, building the person from the inside out."[2]

On his encouraging the personal development of the therapist: "I integrate methods from systemic therapy, gestalt, and transactional analysis. I use much of what I learned from Erickson as a foundation, but I have my own style and perspective. The therapist is more the tool of change than the techniques the therapist uses. An evolving clinician can best facilitate patient evolution. Erickson was a 'people builder,' not a technician. Similarly, I am more dedicated to help clinicians be the best therapists than helping them to learn techniques to do therapy. Therapist development, moreover, motivates and inspires clinicians and obviates burnout."[1]

On what he calls the "gift wrapping" of suggestions: "Patients gift wrap their problems within symptoms, and the therapist must unwrap the symptom to discover the problem. Similarly, therapists can gift wrap solutions and suggestions within techniques such as anecdotes and metaphors, encouraging the patient to activate to realize the intended message. Hence, therapy is an exchange of presents (and presence)."[1]

On communication that is evocative: "Every communication is both informative and evocative. The evocative aspects of the communication have to do with voice tone, tempo, proximity, gesture, all of the paraverbal and nonverbal aspects of communication. Music is an extension of human speech, [and] it eliminates the informative aspect of communication. Music is purely using the evocative aspect of communication. Music is a verb; it's what transforms us into different states. If you watch a movie without the music, you don't feel the experiential impact. So I've been studying the questions, what are the evocative techniques that musicians use and how can we apply them to further our abilities to help people change their states, both in psychotherapy and hypnosis? Beyond musicians, I've been interviewing film directors, composers, and visual artists of all kinds. So while the first part of my career was modeling Milton Erickson, now I'm modeling art trying to understand the evocative nature of communication.… I think clinicians should know how to use evocative communication."[2]

On the artistry and science of hypnosis and Erickson: "The most widely known research on hypnosis focuses on the nature of the phenomena, not on clinical outcomes. The major hypnosis researchers of the 20th century were scientists, not clinicians. Erickson's first career was as a researcher, and he was more like an anthropologist conducting field studies than a modern psychological researcher armed with an ANOVA [analysis of variance, a statistical analysis tool]. Because there is a lot to be learned, I hope that some of Erickson's research methodologies will be resurrected and modernized."[1]

[1] *Personal communication, January 15, 2003.*
[2] *Personal communication, December 8, 2010.*

individual experiences are necessarily different. Taking their words, then attaching your meaning to them, then translating them into the conceptual language you happen to use, and then, finally, communicating from your linguistic style are all steps that are arbitrary on your part and thus increase the likelihood of miscommunication. Thus, in using their language you can't assume, even for a moment, that you mean the same thing they do. You can use the same language as your clients simply because it is their world you are dealing with, not yours.

Words are symbols of experience, not the experience themselves. They represent a distortion (i.e., a distillation) of real-world experience anyway, so why distort them even further with new labels that are mostly of interest only to the clinician? I have had clients who saw other therapists that helped them "resolve transference issues," "build ego strength," "strengthen their armor," and "release energy blocks." They did these and lots of other things that pleased their therapists, yet they left treatment not feeling much better about themselves. The main advantage of using clients' language is found in your ability to intervene in their problem as they experience it, not as you interpret it. Furthermore, clients can get the sense of being understood to a greater degree, engendering greater trust in the clinician.

The ability to use language skillfully and creatively takes considerable practice. Psychologist Jeffrey Zeig has been an especially powerful presence as a clinician, teacher, and writer in this regard, regularly modeling what the mastery of communication skills looks and sounds like.

Sometimes, using clients' language is neither appropriate or desirable. If their style of speech is too idiosyncratic or is related to their particular ethnic group or other subculture of which you are not a member, then your using the same language to try to make a positive connection may instead be viewed as mockery and insulting. Recovery from such a mistake is difficult.

Some clinicians have a personal bias against using clients' language. I had an interaction a while ago with a prominent therapist who believed that if a patient of his used common language to describe a problem, it was his duty to make a point of speaking back to the person with the proper scientific jargon. When I offered my reaction for some discussion, he said, "I didn't go

to school to speak like an ignorant layman." Well, I didn't go through all the schooling I did for that purpose, either. Might he reach a wider range of the people he works with by working with them in terms they naturally use and can understand instead of expecting them to come to his level? Probably. And, likewise, are there patients of his relieved by his treating personal problems more professionally and scientifically? Probably. The point I'm making is about the value of considering the use of clients' language to possibly enhance the interaction. It takes a lot of flexibility to want to do that, though.

HAVE CLIENTS DEFINE TERMS EXPERIENTIALLY

Since words are simply symbols of the experiences they represent, using the same words as your client doesn't mean you are describing the same experience. Therefore, it is imperative to have clients explain to you the details of what they are experiencing as best they can rather than just using a word or two, such as a diagnostic label, to represent the experience. Whatever descriptive words are used will never give you a complete idea of what individuals are subjectively experiencing, but the more definition and description of their experience you have the more opportunities you have for meaningful intervention.

Some clinicians are afraid to ask clients for clarification, erroneously believing it will reflect a lack of understanding. Thus, when a client says, "I have this terrible depression; you know what I mean?" the eager-to-prove-understanding therapist is likely to say, "Yes, I know what you mean." The clinician may know what depression is from previous experience, personal and professional, and so puts this client into the same category as others termed *depressed*. However, what this particular client is actually experiencing is unknown. A more effective response might be, "Can you describe what your experience of being depressed is like for you?" Having clients describe their experience in their own ways can lead you to a better understanding of how and where to intervene. We are invariably striving to alter their actual experience, not the labels they use to represent it.

In having clients define the meanings of the terms they use, the clinician can often help them redefine the term and subsequently alter the experience it represents. This is the essence of a technique called *reframing*, in which an experience is changed by the use of a different term to redefine the experience. Thus, *cheap* can be altered to *fiscally conservative*, a *retreat* can be reframed as a *strategic military withdrawal*, and *weird* can become *uninhibited and eccentric*.

Words are the medium of exchange between the clinician and client, and the more ambiguous the words, the greater the room for miscommunication. This point emphasizes the need to be aware of both the connotative and denotative meanings of your words. If a client takes literally something you intended to be taken figuratively or vice versa, the result may be an undesirable one.

USE THE PRESENT TENSE AND A POSITIVE STRUCTURE

Generally, suggestions should be phrased in the present tense and in terms of what people are currently experiencing. Of course, most therapeutic suggestions are intended to influence future behavior in some way, but the hypnotic session is the bridge between what is happening now and what, hopefully, will happen later. The basic structure of hypnotic suggestions is linking what is occurring now to what is desired: "As you experience this, you can start to experience that." Continuous feedback about individuals' present state is necessary to make the bridge effective.

This point is especially true in the case of working directly with variables of time, such as in age regression. When you are working with memory, talking to the person in past tense terms of what occurred "then" will produce a different and much less profound response than will talking to clients as if they are experiencing that past situation right now. In part, this is where hypnosis as a tool derives its power. Instead of intellectually talking about a situation one is psychologically removed from, the clinician recreates that experience here-and-now and deals with the resulting issues as they arise now.

Negative suggestions were described in the previous chapter. Caution was advised then about the potential for their inadvertent misuse. In general, suggestions should be phrased in positive ways as to what persons can do instead of what they can't do. Remember the effect of me directing you not to think of the taste of pizza? Suggesting to someone what not to do has the same effect as being told what to do in part because of transderivational search and in part because it does not provide an alternative focal point. An analogy about learning through reward or punishment might be useful to elaborate this point. In simply punishing someone for doing something wrong, there is nothing provided to tell the person what the right thing is to do. The person merely learns what not to do; receiving repeated punishment with no alternatives provided leads to frustration, anger, and finally a point where punishment is no longer effective.

Providing positive suggestions that assist clients in discovering what they can do differently to resolve troublesome issues is a principal goal of treatment. Negative suggestions can be effective when carefully used, but the overwhelming majority of suggestions you use will likely be of a positive nature to help build meaningful associations.

ENCOURAGE AND COMPLIMENT POSITIVE RESPONSES

The process of encouraging a client is typically one of guiding clients into a self-aware position where they can identify and acknowledge personal

strengths and previously overlooked resources. Typically, people seeking help feel out of control and frustrated. Paying clients seemingly empty compliments that contradict their low self-esteem is easily disregarded (recall the earlier discussion of cognitive dissonance). Guiding them into a position of self-acknowledgment by contradicting their negative self-generalizations, then confirming and complimenting that recognition has been a powerful intervention, in my experience. Having clients reach a conclusion that they are better off than previously assumed can be a more profound experience for them than simply hearing me say so.

Some clinicians are of the belief that clients have to be "torn down" before they can be "built up." For them, therapy often consists of attack, negativity, and disrespect. I don't support such views and believe that clients must be approached with respect. Clients' behavior is not them; rather, it is a reflection of what they don't know, what they know that isn't so, and what choices they perceive as available at a given moment. The clinician's role is to provide new alternatives that are more adaptive for them. When the new choices fit clients well and are provided with acknowledgment of their integrity, the process of change can be considerably smoother.

Another dimension of the suggestion to encourage and compliment clients relates to the notion of accepting their communications as a means for facilitating hypnotic induction and utilization of the hypnosis for therapy. This is the essence of the "utilization approach," derived from the work of Milton H. Erickson. Its underlying pragmatic principle is "accept and utilize" client responses. The sophistication of the utilization approach lies in its accepting rather than contradicting clients' subjective beliefs, values, and experiences and then striving to discover a way of utilizing them to facilitate change. For example, if a client says, "I'm a no-good crazy person" and the clinician responds, "No, you're not; you're a good person who is just confused," the clinician has not accepted the client's view of himself. Part of forming a meaningful response is determining whether such a self-effacing statement is a genuinely felt one or just a manipulation to get a free compliment. But accepting the client as he sees himself, responding with something such as, "You may think you're a no-good crazy person right now, but I couldn't help but notice how much sense your no-good craziness has made given your circumstances, which means you have some sense even you don't know about just yet," is simply the first step toward attaining a position with him from which to effect meaningful changes. Furthermore, it allows for the message "What you are doing right now is fine, because that is exactly what will allow you to accomplish the change you desire." Accepting the current state of affairs without a critical reproach is desirable to encourage clients to use the bridge of the intervention to reach the desired goals.

DETERMINE OWNERSHIP OF THE PROBLEM AND PROBLEM-SOLVING RESOURCES

Different therapeutic approaches have different terminology to express this concept, each one addressing the need to guide clients into accepting some measure of responsibility for what they are experiencing. If clients feel like they are a "victim" or are a "blamer" with no awareness of personal responsibility at all for their experience, then helping them to change in some meaningful way is more difficult. As a victim, if you believe you have no control over your experience, then attempts to motivate you to do something to help yourself will most likely be ignored or dismissed with the ever-familiar, "Yes, but …" excuses of why change is impossible. Helping people to discover that they have power to control, at the most, the events in their lives or, at the least, their reactions to the events in their lives is a routine and necessary component of therapeutic work.

The underlying goal is to empower people, a foundation for all health professionals in the work they do. People don't get better when they see themselves as victims and blame others for their problems, even when others really are responsible for causing them grief. Rather, they get better when they sense they can influence the course of their problems or the intensity of their symptoms. Thus, it is an essential part of treatment that persons define themselves as participants in the process of change, owners of problem-solving resources and not just as having a sense of victimhood.

USE SENSORY MODALITIES SELECTIVELY

Most people have a preferred sense that is more well developed and more heavily relied upon in processing day-to-day experience. This is called the primary representational system, and it's one of the many ways people differ from one another. Some people are more detailed in their visual skills, meaning they tend to think in pictures, remember or imagine images more clearly, and process the visual portion of experience more completely. Other people favor the auditory modality, thinking in terms of internal dialogue, talking to themselves about their experience, remembering or imagining sounds and conversations with great clarity, and processing the auditory portion of ongoing experience more completely. Still others favor the kinesthetic modality, thinking in terms of feelings, remembering or imagining the feelings associated with various experiences with clarity, and processing the kinesthetic portion of ongoing experience more completely. Olfactory and gustatory representations can be just as powerful in shaping emotional and behavioral responses.

A primary representational system describes the dominant sense in individuals' awareness at a given moment in time, but it is not the only sensory experience they are aware of. Nor is it a stable phenomenon since the dominant

modality changes from context to context. In fact, assuming all senses are intact, all people process experience in all of the senses all of the time. The issue of clinical concern here is knowing which modality is dominant in a given context, particularly the symptom context. If a clinician can identify clients' favored system of sensory experience, they can choose to adapt communications to that favored system and possibly increase the likelihood of meaningful influence through the attainment of greater rapport.

The language individuals use spontaneously, particularly the predicates, including verbs, adverbs, and adjectives, reflects their favored information-processing style. Language, because it is structured for the most part at an unconscious level, reflects the unconscious patterns of thinking through the specific words chosen to reflect inner experience. Thus, if in the course of a discussion I make a point that the listener responds to by saying, "I *see* what you mean; that *looks* right to me," I can deduce a visual preference in the listener relative to my point. If the listener responds to my point by saying, "I *hear* what you're saying; that *sounds* right to me," I can deduce an auditory preference. If the listener responds, "I get *a feel* for what you mean; that idea *grabs* me," I can deduce a preference for the kinesthetic modality. In each case, I can use language that will appeal to the preferred style. For example, with a visually oriented person, using visual imagery techniques is likely to be effective but may be less effective with the person who has a strong kinesthetic orientation.

A study I published (Yapko, 1981) demonstrated the greater depth at which research subjects could experience hypnotic relaxation when the induction's predicates were matched to their preferred modality. The matching of predicates to facilitate hypnosis is simply another way of using clients' language while acknowledging their uniqueness. Furthermore, since all experience can ultimately be broken down into its sensory components, the use of language patterns that emphasize the sensations of an experience will have a more powerful effect than the use of more distant, intellectual terminology. Consider the effect of the following statement:

> Think of how pleasant a walk in the woods can be … so enjoyable and peaceful.…

Contrast that effect with a more sensorily rich statement:

> Can you remember taking a walk in the woods … seeing the tall, sturdy trees and bright green leaves contrasting against the sunny blue sky … hearing the soothing sounds of the birds chirping and singing and the leaves crackling underneath your footsteps … the gentle feelings of comfort and peacefulness inside …?

The experience of hypnosis is one in which clients' emotions and sensory experiences can be amplified to higher levels, appropriate for making greater use of

their resources in facilitating change. The greater power is in the use of emotional, sensorily descriptive language instead of intellectual language that appeals primarily to the conscious mind, the lesser force in guiding human behavior.

The best sensory-based descriptions are those that influence clients' experience the most. Therefore, it is of great advantage to be able to listen to them, to identify their most relied on modality for the experience under consideration, and to adapt the hypnotic process to that modality. In this way, a greater rapport may be obtained, and the stage may be set for leading clients into a different sensory awareness. Such a lead may be accomplished by shifting at some point into using language of the sensory systems outside of individuals' usual awareness. For example, with people whose favored modality is visual, you can match with visual suggestions and then gradually lead into the kinesthetic area, altering their typical pattern of consciousness:

> As you see yourself sitting in that chair, you can see each breath you inhale soothing each muscle of your body … visualizing each muscle unwinding, loosening comfortably … and as you see each muscle relaxing you can begin to feel the tingle of comfort in the muscles of your arms … and feel the comfort growing and flowing to other parts of your body.…

KEEP CLIENTS AS INFORMED AS DESIRED AND AS NECESSARY TO SUCCEED

While it is a high priority to provide relevant information to clients and the ethical practice of securing an informed consent is highly desirable, it is also clinically necessary not to provide too much information about one's interventions. Giving clients the opportunity to develop defenses by analyzing and criticizing what the clinician is doing is counterproductive to the aims of therapy. Rather than explain why I am doing whatever I'm doing, most frequently I just do it. The spontaneity from the experience of my communications is what has an impact on individuals, not the explanation of what I am trying to do. If I say to a client, "I'm going to give you a negative suggestion now in a 'reverse psychology' strategy so you'll think you're spontaneously doing what I tell you not to do," what is the likelihood of me getting the response I want? Answer: Zero.

Presenting and withholding information selectively can be an obvious ethical dilemma (Scheflin, 2001; Zeig, 1985c). How can clients provide informed consent if they don't know what the clinician is doing and why? Yet if they know exactly what the clinician is doing, then how can the intervention succeed? This is a matter that must be handled delicately on a case-by-case basis, as the clinician gets a "feel" for how much information clients want and need to succeed.

One of the most interesting dimensions of Erickson's work was his ability to obtain compliance from his patients to demands he made on them that were

sometimes nothing short of outrageous. Erickson lived in an era where a doctor's authority went virtually unchallenged, so if he asked his patient to climb a mountain to symbolically gain a greater overall view of things, the patient usually would. But, a more likely response in today's therapy climate is, "Why? I think I'll get two other doctors' opinions." If Erickson explained why he wanted the patient to climb the mountain rather than let the client discover it independently, would it have the same therapeutic impact? Yet doesn't the patient have a right to know?

People often asked Erickson how he motivated people to do the things he wanted them do (Haley, 1973; Zeig, 1980b). His answer was simple: "Because they know I mean it." Trust, rapport, and respect for clients' integrity are key ingredients in the hypnotic interaction.

GIVE YOUR CLIENTS THE TIME THEY NEED TO RESPOND

All people do things according to their own personal pace. During hypnosis, this characteristic is amplified to the point of being a critical component of the interaction, one to be noticed and respected by the clinician. To pressure someone to respond to your pace of doing things just won't work in doing hypnosis. Instead, you have to allow clients to form the suggested response at the rate they choose. Most people can't generate instant hypnotic phenomena. They need some time to do so. Imposing a time limit on clients' responses is more typically a beginner's mistake, caused by uncertainty and a lack of experience. Often, students in my introductory courses who are first learning to do hypnosis might suggest an arm levitation, for example, and if the subject's arm doesn't immediately begin to lift, students may get agitated and assume the subject is resisting or that they are doing something wrong. If they start to repeat themselves and badger their partner with their suggestions, I will stop them and instruct them to simply wait. Almost invariably, after a short while, the subject's arm begins to lift and students have now learned to be a bit more patient in letting the subject respond in his or her own time.

In the phase of guiding individuals out of hypnosis, called *disengagement* or *alerting*, this is especially true. I have always disliked using a count-up to guide the person out of hypnosis (e.g., "When I count to three you will come out of hypnosis, open your eyes, and be alert and refreshed"). It forces clients to adapt to your arbitrary demand as to when they should come out of hypnosis instead of letting them choose independently. I prefer a general, permissive suggestion for closure such as, "When you have taken the time to complete this experience, you can bring yourself out of hypnosis at a rate that is comfortable for you."

Let clients take the time they need to fully develop the hypnotic responses you suggest. There is no need to hurry.

USE TOUCH ONLY SELECTIVELY AND ALWAYS WITH PERMISSION

Can you imagine what it's like to be deeply relaxed, feeling good, wonderfully absorbed in some important internal experience—and all of a sudden feeling a strange hand touching you? I have seen so many sessions that were going well ruined in an instant because the clinician assumed enough rapport was present to touch the person—if she even thought about it, which some "touchy-feely" clinicians never do. The touch was always entirely innocent, was a well-intended expression of support or empathy, and yet was highly disruptive to the client. It is essential to always get permission to touch the person for a number of reasons.

First, touch is associated to intimacy; it's crossing a line into someone's personal space. Some clients may welcome it, but others hate to be touched and experience it as a violation of personal territory. With such persons, it can hinder or even destroy rapport in just one careless moment. Second, in hypnosis, the person is typically, though not always, focused inwardly on some internal experience. To have to notice or respond to a clinician's touch means reorienting one's focus to the external world, generally counterproductive to the development and maintenance of a deeper experience of hypnosis. If you use touch indiscriminately, you can thus unintentionally work against yourself.

Third, an unexpected touch may simply startle people, even if they don't find it offensive. They may be so lost in thought that they may have forgotten that you are even in the room. To suddenly and unexpectedly feel a hand on you can scare anybody, in or out of hypnosis. Fourth, the media have played on the terrible misconception that hypnosis is a means for seducing vulnerable clients. The sexual implication of touching someone unexpectedly can easily trigger unnecessary problems in this sensitive domain.

The great majority of the hypnosis sessions you do will not require you to touch clients. However, sometimes you will need to, such as when you want to gauge the level of anesthesia they are experiencing when doing pain management sessions or perhaps when providing a supportive hand to hold when dealing with some difficult material. It is always a good idea to politely ask clients for permission to touch them during hypnosis, for it certainly demonstrates a respect for their integrity. You can ask before your hypnosis session begins by saying something such as, "During this session I will want to touch the back of your hand to gauge your degree of analgesia.… Is that all right with you?"). Or at some time during the hypnotic process you can ask for permission by saying something such as, "In just a moment I'd like to lean over and touch you lightly on your wrist. If that's okay with you, please signal me by raising an index finger." Some practitioners prefer to do one or the other, but I personally prefer to do both.

USE ANTICIPATION SIGNALS TO ANNOUNCE YOUR INTENTIONS

For the reasons elaborated in the previous section, it is obviously a good idea to avoid shocking clients out of hypnosis with some unexpected maneuver on your part. The best tool to prevent this problem from arising is called the *anticipation signal*. Anticipation signals are explicit announcements of your intentions, effectively letting your clients know what action you are about to take so as to not startle them. They also serve the deepening function of keeping clients comfortable enough to feel as though they don't have to pay conscious attention to everything you say and do. Such vigilance is generally counterproductive to hypnosis.

Anticipation signals are simple statements you make during hypnosis about what is coming next in the process. The generic structure for an anticipation signal is, "In just a moment, I'm going to (fill-in-the-blank)." For example, I may say, "In just a moment, I am going to be silent for a minute while you deepen your experience." Assuming I have been talking for some time, it would be disruptive if I just stopped and clients had no idea why. By informing them as to what's going on, vigilance is unnecessary. It is a much gentler and more respectful approach, and clients greatly appreciate that consideration. When you state, "In just a moment I'm going to …," and then follow through in a way that is entirely consistent with what you stated your actions would be, a new level of trust in you can be reached, aiding in your future work together.

USE A VOICE AND DEMEANOR CONSISTENT WITH YOUR INTENT

Your tools as a skilled communicator are your voice and body. Beyond your words, your nonverbal communications can serve to reinforce or even negate your suggestions. Paying attention to such factors as eye contact, body posture, gestures, touch, timing, use of space, tone and volume of voice, and facial expressions is necessary to maximize the impact of the things you say. If you don't utilize these nonverbal components of communication well, positive results will be slow in coming, if they come at all.

It helps immeasurably to have control of your voice and body in communicating, using yourself as the mechanism to drive a suggestion home. To have tension in your voice when you suggest to your clients that they relax is an avoidable incongruity. To use a normal conversional tone of voice with someone you want to guide into a different internal state of experience is another avoidable incongruity.

It is a good idea to have a well-practiced calm tone of voice and a relaxed body posture to model for your clients the comfort you want them to experience. To gradually shift from your usual tone of voice to one that's slower and more soothing builds an association (what some call an *auditory anchor*) in clients' minds between that tone of your voice and the implied invitation to go into hypnosis. Establishing that association makes it a smoother transition into doing hypnosis in subsequent sessions. Once clients associate going into hypnosis with that tone of your voice, you don't necessarily have to formally announce, "Now let's do hypnosis." Instead, you can gradually lead into using the voice your clients associate to entering hypnosis, effectively inducing hypnosis without a formal induction. Using a soothing, comforting voice throughout your process also serves the additional purpose of discouraging conscious analysis, calming the person, and reducing the need for defensive hypervigilance.

The nonverbal components of your communications are critical to generating successful hypnotic experiences in your clients. It can be helpful to make audio- or video recordings of yourself doing hypnosis to learn how you look and sound as you conduct hypnotic processes. Often, people have no idea of how they look or sound as they interact with others, so getting feedback from a variety of sources can be highly instructive.

CHAIN SUGGESTIONS STRUCTURALLY

Like most of the other communication patterns offered as guidelines in this chapter, this particular one is a constant in doing hypnosis. *Chaining suggestions* means linking the desired response to clients' present experience. The idea is to build links, hence the term *chaining* between what clients are currently doing or experiencing and what you would like them to do or experience. The generic suggestion structure for chaining suggestions is, "As you experience (this), you can start to experience (that)." For example, as you continue to sit there and read these words, you can begin to notice your left foot.

As Bandler and Grinder (1975) pointed out, there are three types of links between current and future experiences, varying in the strength of the linkages. As will be true with all three links, the first half of the statement matches (paces, accepts) individuals' current experience while the second half suggests (leads, utilizes) a possible, but not current, experience.

The first link is called the *simple conjunction*. It is the weakest link and simply suggests an association between what is and what can be. It employs such connecting words as *and* and *but*. For example:

- You are looking at me *and* starting to feel comfortable.
- You can see the clock clearly *but* still allow time to slow down.

The second link, and a slightly stronger one, is called the *implied causative*, employing such connecting words as *as, while,* and *during*. For example:

- *As* you notice yourself relaxing, you can let your eyes close.
- You can listen to me *while* your conscious mind drifts off.
- You can feel yourself growing more comfortable *during* your experience of vividly remembering your high school graduation.

The third and strongest link is called the *causative predicate*. It's the strongest because it claims that not only are the current and desired behaviors connected, but one actually causes the other. For example:

- Breathing deeply will *make* you relax even more.
- Shifting your body's posture will *cause* you to want to close your eyes.

Each of these links forms a bridge to get the client to respond in a particular way on the basis of what he or she is doing currently. A typical hypnotic process, using the "As you X you can Y" chaining formula, may sound something like this:

> As you continue to look at me, you can take in a deep breath … and as you take in a deep breath, you can allow your eyes to close … and as your eyes close, you can let your mind drift back to a specific memory … and as your mind drifts back to a specific memory you can begin to describe the memory out loud … and as you begin to describe the memory out loud you can.…

Structurally, each suggestion is chained to the response before it, starting with a statement feeding back to clients their current, undeniable reality: that they were looking at me and in so doing could take in a deep breath. Looking at someone and taking in a deep breath are not usually connected and in this example are connected only by an arbitrary link of my own creation. Each response is then fed back (paced, accepted) as the basis for the desired response (the lead, or utilization).

Suggestions linked in this way are the basis for the hypnotic process being a flowing one rather than a choppy, disconnected one in terms of delivery. Grammatically, of course, hypnotic phrasing is a strict grammarian's nightmare, but to persons in hypnosis the clinician is smooth and easy to listen to.

USE PROCESS SUGGESTIONS TO ENCOURAGE PROJECTIONS

If you refer back to the last chapter's section on process suggestions, you can recall the general principle that the more details you provide for someone's hypnotic experience, the more opportunities there are for unintentionally contradicting it. For example, "Let your right hand feel warmer" as a suggestion for

the specific response of hand warmth is easier to resist than is a more general process suggestion: "You may notice a particular change of temperature in one of your hands." In the latter suggestion, which hand was to change was not specified, nor was it specific whether the hand was to grow warmer or cooler. Whatever response the person generates can now be defined as a cooperative one.

It is difficult, if not impossible, to fully avoid the use of detail in suggestions. And it is not always desirable to do so because often it is the details you provide during the hypnotic process that make suggestions easier to follow and more effective. Learning to "be general specifically," that is, sounding specific but being general, can help you avoid some of the unnecessary rejections of your suggestions. Notice as early on as possible whether you are being too specific or too general on the basis of clients' feedback to you, and, if necessary, shift your style as you continue on.

BUILD RESPONSE SETS GRADUALLY

As the hypnosis session begins and starts to develop focus and momentum, building clients' responsiveness to your suggestions incrementally is a primary goal. As stated before, most people aren't immediately responsive or instantly capable of generating hypnotic phenomena. The term *building a response set* refers to building a pattern in clients of fuller and more consistent responding to suggestions.

The most commonly used response set in the clinical context is one commonly known as the *yes set* described by Erickson (Erickson, Rossi, & Rossi, 1976; Erickson & Rossi, 1979). A yes set on the part of clients is a patterned response of accepting—in essence saying yes to—the suggestions you provide. Building an agreeable frame of mind is valuable at any time during the hypnosis session but is especially important at the outset when you are first establishing the therapeutic alliance with them.

The most common means of establishing a yes set is with the use of a series of truisms, the suggestions you learned about in the last chapter that involve making statements that seem so obviously true there is no legitimate basis for rejecting them (e.g., "Sometimes people surprise themselves by knowing things they didn't know they knew …"). As you offer three or four truisms in a row, clients silently agree with each. If you agree with statement number one, then again with statement number two, then statement number three, and then statement number four, what is your most likely response going to be to statement number five? Agreement.

In general, when doing hypnosis, your session progresses from general to specific. Before you ask for *specific* hypnotic responses, such as an analgesia, you first have to build a momentum in clients' responsiveness that will facilitate such a complex response. So you might first offer a series of general

statements (e.g., truisms) about ways they can begin to think of her physical perceptions being malleable. For example:

> The human body is so complex in its many organs and organ systems … and isn't it interesting how our perceptions of our bodies change from time to time … sometimes you feel warm, and sometimes you feel cool … and sometimes you feel tuned in to your body, and sometimes you feel distant from it.…"

Once a general sense of variability in physical perception has been established, the clinician can then go from general to specific in suggesting a particular change in physical perception, such as developing an analgesic.

The yes set is the most commonly used one for what are now obvious reasons, but there are other types of response sets as well. There may be times when you want to deliberately encourage rejection of your suggestions, perhaps to foster greater independence, for example, with a *no set* in which you offer statements you know the person will reject. Or there may be times when you want to encourage skepticism or uncertainty with someone who is very confident but very wrong with an "I don't know" set, offering statements about the ambiguity of things like when consciousness emerges or what happens after we die.

The skilled clinician recognizes the importance of taking the time to build responsiveness in clients as the session progresses. In fact, if you were to ask me what single stage of the interaction most influences the overall success of the hypnosis session, I'd say it's the stage of deliberately building a response set.

IF DESIRABLE, SUBSTITUTE OTHER TERMS FOR HYPNOSIS

I don't have a particular fondness for the word hypnosis, so whether one calls it hypnosis or calls it something else isn't an issue of significance for me. As long as the suggestive dynamics are operant, regardless of the chosen name, hypnosis is present. Hypnosis is a part of virtually every therapeutic modality I am aware of, but almost always under another name and woven into a different conceptual framework. In fact, I wrote a book about the hypnotic aspects of mindfulness called *Mindfulness and Hypnosis: The Power of Suggestion to Transform Experience* (Yapko, 2011b). Beyond the name, the principles and mechanisms of action are the same. The key disadvantage to hypnosis being so disguised that people practicing similar techniques don't recognize it is that it might well make others' work more precise if they directly studied and utilized hypnotic principles and methods without diffusing or diluting them.

Since I have no real attachment to the word hypnosis, if it serves the therapy to use all the same principles and techniques under a different, more

acceptable, name, I will do so. If a cancer patient fears hypnosis yet really wants to experience the anticipated benefits of visualization techniques, why get into a lecture on how visualization is a specific type of hypnotic technique? It may create resistance needlessly. Instead of developing a positive feeling for hypnosis, the patient might develop a negative feeling about visualization.

There are many clients for whom the word hypnosis inspires fears and doubts, yet these same clients are happy to learn "progressive relaxation," a specific hypnotic induction technique. It isn't terribly important to sell your clients hypnosis; it's only important to help them have positive and therapeutic experiences with it. If clients react negatively to your query about any experience they might have previously had with hypnosis, you might exercise the option of using another term to label your intervention. Some specific possible alternative labels are:

Progressive muscle relaxation
Controlled relaxation
Guided relaxation
Deep relaxation
Visualization
Visual imagery
Guided imagery
Guided fantasy
Guided meditation
Mental imagery
Selective attentional training

Do these terms all represent hypnosis? Technically, the answer is no. These approaches are each different in a variety of ways, so the hypnosis purist will likely find it incorrect to equate them. And he or she would be correct to object. However, in clinical practice, quibbling about minor differences wastes time and creates unnecessary conflict when all we want to do is help empower clients to focus and develop important personal resources.

Whatever variation you might use, as long as a focused state of attention is narrowed to suggestions offered, dissociated experience and influence occurs as a result, then hypnosis is present. Hypnosis may be in effect without necessarily identifying it as such. If it works to clients' advantage somehow to call it by another name, it would seem wise to do so.

CONCLUSION

Table 16.1 summarizes the patterns discussed in this chapter. While this chapter covered some of the fundamental components of hypnotic communication,

Table 16.1
Some Helpful Hypnotic Communication Patterns

Keep your suggestions simple and easy to follow.
Use clients' language as much as sensibly possible.
Have clients define terms experientially.
Use the present tense and a positive structure.
Encourage and reinforce clients' positive responses.
Determine ownership of the problem and the problem-solving resources.
Use sensory modalities selectively.
Keep clients as informed as desired and as is necessary to succeed.
Give clients the time they need to respond.
Use touch only selectively and always with clients' permission.
Use anticipation signals to announce your intentions.
Use a voice and demeanor consistent with your intent.
Chain suggestions structurally.
Use process suggestions to encourage projections.
Build response sets gradually.
If desirable, substitute other terms for hypnosis.

it obviously could not cover all the subtleties inherent in doing hypnosis. You may be reminded that for each general principle discussed, there are also exceptions.

FOR DISCUSSION

1. How do you react to being touched spontaneously by people you don't know very well? How might a spontaneous touch be viewed as an invasion of territory even if it was well intentioned? Why do some people dislike being touched?
2. What, if any, is your most well developed sensory modality for information-processing? What implications does this have for your style of intervention? What advantages and disadvantages does it pose in your life?
3. Is language formed at an unconscious level? How do you know?
4. What communication patterns seem to help you experience hypnosis more fully? Why do they seem to have that effect on you?
5. What is "personal responsibility"? How far does responsibility for one's self go when others' behavior clearly influences us on a continuous basis? How do you know when someone isn't accepting personal responsibility?

THINGS TO DO

1. Analyze a commercially available hypnosis recording for its communication patterns. What patterns seem especially effective to you? Which seem disruptive?
2. Make a list of five therapeutic approaches (e.g., cognitive, behavioral, psychodynamic) you find interesting or valuable and list the primary techniques associated with them. How is hypnosis a part of each?
3. List at least one context in which each of the patterns described in this chapter would not be applicable.

CHAPTER 17

FORMAL STRATEGIES OF HYPNOTIC INDUCTION

People routinely enter conditions of experiential absorption, focus, and dissociated awareness spontaneously, that is, without any formal ritual of induction taking place. While it is arguable whether these spontaneous hypnotic experiences are the same as hypnosis produced in either the laboratory or clinical setting, at the very least they clearly share many common characteristics. Theoretically, then, inducing hypnosis in others shouldn't be a particularly difficult thing to do. In fact, usually it isn't all that difficult to do, although it can be made difficult if the client has poor concentration, low motivation, negative expectations, or fears about hypnosis or if the interpersonal dynamics of communication and influence aren't skillfully applied in an appropriate context.

The phrase *inducing hypnosis* implies the clinician is doing something to clients. The language of hypnosis is sometimes limiting and even misleading, for clients are not simply passive receptacles for the clinician's suggestions (Zeig, 2011). Rather, clients are an active force in shaping the interaction, and the clinician must respond meaningfully to their unique responses. Guiding them into hypnosis may be a more accurate representation of the clinician's role. In the capacity of guide, you cannot know the exact experience clients are having or are going to have, so giving them room to experience hypnosis in their own way is not only desirable but also necessary. The process of guiding clients into hypnosis is a large responsibility to assume as you make yourself a primary focal point, for they are now focusing on the associations you stimulate through your suggestions.

Hypnotic interaction can be thought of as taking place in at least four general stages, as Table 17.1 suggests. Each stage can be broken down even

Table 17.1
Stages of Hypnotic Interaction

Rapport building
Attentional absorption
Hypnotic induction
Deepening (intensification)
Building a response set (increasing responsiveness)
Hypnotic utilization (therapy)
Posthypnotic suggestion
Closure, disengagement

further into subcomponents, and these involve the detailed considerations about doing hypnosis step by step that are presented throughout this book.

Prior to the first phase, orienting clients to hypnosis and securing their attentional absorption through the *preinduction talk* or *prehypnosis interview*, the clinician has already introduced hypnosis to them, explained its merits and purposes, and established a therapeutic alliance (Gibbons & Lynn, 2010; Nash, 2008b). When the clinician says some variation of, "All right, let's begin … you can arrange yourself in a comfortable position," to signal the start of the induction process, he or she has clearly oriented clients to the hypnosis induction about to begin. The clinician has also indicated that clients should now strive to narrow their focus to the clinician's suggestions and the immediate matters at hand. All of the preparations for the hypnotic experience discussed in previous chapters are parts of this particular phase: the discussion concerning personal motivation to change; conceptions about hypnosis; defining personal goals; identifying the specifics of the symptomatology, such as their onset, possible origins, course, and quality of symptoms; assessing client responsiveness (either from formal assessments or informally from the responses to your guidance in the interaction); choosing and applying a communication style; and moving through the interaction in a goal-directed fashion.

This chapter considers the second phase of the hypnotic interaction: the hypnotic induction and the intensifying ("deepening") of clients' hypnotic experience. The process of hypnotic induction serves several purposes:

1. It provides a concrete stimulus on which clients can focus their attention, serving as a bridge between the "normal waking state" and the focused experience of hypnosis.
2. It engages and occupies clients' attention by focusing it on specific suggested experiences. In narrowing the focus, the suggestions for what to notice or experience effectively dissociate their attention from other competing awarenesses while also stimulating idiosyncratic unconscious associations. In fact, this is the chief function of an induction: facilitating attentional absorption and the dissociation

of conscious and unconscious functions. The degree of dissociation achieved is a relative measure of the potential for hypnotic, nonvoluntary responding.

3. It allows for the building of a "response set," a characteristic pattern of responding to the guidance of the clinician, discussed earlier.

The induction process as the stimulus for the experience of hypnosis obviously plays an important role in the overall quality of the interaction, and consequently, deciding which induction to employ is a matter worthy of extra consideration. There are as many induction methods as there are practitioners of hypnosis, and since it is neither practical nor desirable to list them all I have included only several of the more common and useful ones. (For a more expansive array of hypnotic inductions, see Barabasz & Watkins, 2005; Gafner, 2006, 2010; Gafner & Benson, 2000, 2003; Gibbons & Lynn, 2010.) I have divided the methods of induction into two general categories: formal, structured inductions, presented in this chapter; and informal, conversational induction approaches, described in the next chapter.

FORMAL, STRUCTURED HYPNOTIC INDUCTIONS

The formal, structured inductions included in this chapter represent the more traditional approaches to doing hypnosis. In using the term *traditional* to describe these inductions, I have two meanings. The first is for the literal meaning of the word traditional. These techniques have been effectively used for a very long time, handed down from generation to generation of hypnotists. My second meaning of traditional is for the association to a more traditional model of hypnosis in which the process of hypnotic induction is generally more highly directive and ritualistic. The traditional model emphasizes the value of a formal and standardized ritual of induction to clearly define the interaction as hypnosis and to assess clients' hypnotic capacity. The emphasis, therefore, is on determining how well they can respond to an impersonal set of suggestions, a marked contrast to the notion of adapting the approach to them. Psychiatrists Herbert and David Spiegel (Spiegel & Spiegel, 1978/2004, p. 28) described the basis for approaching hypnotic induction in this invariant and structured way as follows:

> By using a standardized induction procedure, which involves systematic questioning regarding physiological, behavioral and phenomenological responses, the variable influence of different operators on the trance performance is minimized and the trance capacity of a subject can be systematically documented.

Each of the formal, structured inductions, if not scripted word for word, has at the very least key phrases and key concepts that are integral to the

technique, thereby defining them. Thus, these key phrases and concepts must necessarily be present for that technique to be employed. In doing hypnosis for the purpose of catalyzing some therapeutic shift in clients' experience, a clinician might choose to employ a structured approach yet still vary at least some of the wording according to their individual needs or characteristics (Weitzenhoffer, 2000).

Shift Approaches When Necessary

These techniques are invaluable in the practice of clinical hypnosis and should be mastered as foundational approaches to hypnosis. Experience will prove to you quite dramatically that you will get a wide range of reactions to the same exact technique, such is the tremendous variation among people. This necessitates having many different approaches in your repertoire so you can shift from one technique to another when desirable. One of the most important skills in doing effective inductions of hypnosis is being observant enough to notice and use the responses you get either to amplify them when they are consistent with your aims or to shift away from them and do something else when they are not.

If what you are doing isn't working for some reason, you can have the flexibility to smoothly shift to a different technique or style. You don't have to stay with a technique that clients are clearly not experiencing as engaging. Stopping midway through a particular technique is a perfectly acceptable and even desirable thing to do when that technique isn't getting the response you want. The key to making such a midstream switch smoothly is in the transitional statement you make to clients leading from where you were to where you are going. You should never comment, "Well, that wasn't working, so let's try this." Instead, you can offer something more accepting and natural such as:

> That's right … you can continue to feel yourself shifting in the chair, wanting to relax … and you can begin to realize that paying attention to me isn't really necessary to have as soothing an experience as you'd like, and isn't it nice to know that you don't have to listen to me … so why not let your mind drift off to something else it finds even more comforting than the things I'm talking about … discovering in yourself the kind of focus that helps you grow more comfortable in your own way.…

Such statements give clients permission to develop the experience of hypnosis in their way without confrontation of so-called resistance or having to stay with a technique that wasn't sufficiently absorbing.

Each of the techniques presented in the remainder of this chapter will include a discussion of some of the basic concepts inherent in the technique as well as a brief sample of the relevant wording.

BEGINNING THE HYPNOTIC PROCESS

In beginning an induction, there are certain minimal responses you will likely want from clients. None of these are essential, since people can even experience hypnosis and generate hypnotic phenomena while active and alert, but they are basic to clinical contexts where putting clients at ease and building receptivity are crucial.

Suggesting, directly or indirectly, that clients assume a comfortable physical position is a good starting point. A general immobility called catalepsy is typical of the hypnotized individual, and the extra effort it takes to readjust clients' position while in hypnosis make it necessary to be sure they are in a comfortable position they can remain in effortlessly over time. Sometimes the effort needed to adjust their position seems so great that they choose not to expend the energy and, puzzling as it may seem, sit uncomfortably. That tells you how absorbed someone can be mentally: even a simple physical shift is too distracting to bother with having to make.

A second consideration may be to suggest a comfortable rate of breathing; you may notice with experience that a sense of anticipation and fascination sometimes leads clients to breathe irregularly and even hold their breath unconsciously. It helps to relax people to encourage a slowed, more rhythmically even breathing. In fact, many forms of focusing methods, most notably mindful meditations, routinely utilize breathing as the predominant suggested focal point. Breathing is inevitable and thus reassuring, and it is a concrete representation of trustworthy unconscious processes. Breathing is good.

A third consideration is helping clients turn their focus increasingly inward; suggesting that they close their eyes at the start is generally a good idea. Eye closure blocks out external distractions, encourages internal absorption, discourages reality testing, narrows attention to the clinician's suggestions, and thus facilitates the induction. An exception to this is the "Eye Fixation" technique induction, described later in this chapter, which encourages eye closure as the basis for the induction itself rather than as a lead-in to induction.

Suggesting that clients close their eyes can be done directly or indirectly. Generally, I just ask, "Can you … close your eyes?" which people routinely take as an implied directive to do so and respond accordingly. Modeling eye closure is also a good technique; you can slowly close your own eyes while suggesting to clients, "You can close your eyes … now … and allow yourself to relax comfortably." Don't keep your eyes closed, though, because the only source of information about your clients' responses is them, and they will be much too difficult to see if your eyes are closed. It is a good practice to keep your focus on them throughout the entire session. You can't utilize a response if you don't first notice it.

The final consideration at this beginning point is to use whatever behaviors clients offer as the basis for going into hypnosis. This is one aspect of what is

called utilization in hypnosis and can be accomplished by commenting on client behaviors and tying them to suggestions of relaxation and entering hypnosis: for example, "Each shift in your chair can make you more comfortable.… Each breath you take in can soothe and relax your body.…"

As clients grow more comfortable and responsive to the clinician, the hypnotic induction can now get under way. Here, then, are specific techniques for the induction of hypnosis.

Progressive Muscle Relaxation Techniques

Relaxation reduces stress, anxiety, fear of change, and defensiveness and provides a sense of empowerment to clients. Things can simply seem more manageable, less overwhelming, when you're more relaxed. Hypnosis is much, much more than just relaxation, of course, but relaxation is commonly used as a therapeutic stepping-stone for all of these reasons (Barabasz & Watkins, 2005; Nash, 2008b).

The progressive muscle relaxation technique, originated by physician Edmund Jacobson (1938), involves offering suggestions of relaxation of the various muscle groups of the body sequentially (Coe, 1993; Kirsch, Lynn, & Rhue, 1993). The body is divided into as few or as many specific muscle groups as you wish, depending on how long or short you think the induction process need be. You can start with clients' head and work downward to their feet, or vice versa, as a matter of personal preference. One of the questions I am asked most often is where in the body to begin. Working downward carries an implication of going "down into hypnosis," but physical relaxation is generally easier to accomplish than is mental, so working upward leaves clients' mind last in the sequence. In my experience, it's "six of one and half a dozen of the other" in terms of which direction of sequencing may be more effective.

A progressive muscle relaxation technique may be worded as follows:

> In just a moment I will begin to describe the various muscles of your body … and as I describe them relaxing you can notice how easily those muscles begin to relax … and how much more comfortable you feel as they do … and as you continue to breathe comfortably at a slow and easy rate … you can notice how the muscles of your feet can start to relax now … you can feel the muscles of your toes, your arches, your ankles all relaxing wonderfully easily, even feeling the tingle of comfort soothing those muscles, relaxing you easily … and now you can notice how the muscles of your calves and shins relax, growing more comfortable moment by moment … and now the muscles around your knees can relax … and now the muscles of your thighs can feel more at ease and comfortable … and now the muscles of your hips and buttocks can relax … and now you can notice the muscles of your abdomen and lower back growing loose and comfortable … and as the muscles of your back and chest relax with each breath, you can feel more and more at ease … and then

> your arms can grow heavier and more comfortable … and now your neck muscles can grow loose and limp … and finally the muscles of your face and head can relax and leave you feeling so comfortable, more relaxed than you've been in a long, long time.…

This example is an abbreviated version of what can be a much lengthier and more drawn-out process. You can be as repetitious and as slow with your suggestions of comfort at each specific muscle group as clients may require. The pace at which you move through the sequence has to be based on their reactions. You can go slower if they are quite tense or move along at a faster pace if they are able to get comfortable and focused quickly. A client who is either hurried by too rapid a pace or bored by too slow a pace is likely to be too easily distracted and disengaged from the induction process. Remember, when your suggestions don't fit well with clients' ongoing experience, they are much easier to reject.

The progressive muscle relaxation technique can take a considerable amount of time to do, perhaps as much as 20 minutes, but usually only at first. With repetition, the association of relaxation is formed to your mere mention of bodily relaxation, and usually after a short while of clients practicing this technique the relaxation response develops quite quickly. After a period of practice, simply going through the naming of the body parts in sequence without providing all the detailed suggestions of relaxation will still elicit the relaxation response from clients as a result of conditioning. This is what makes a lengthy, detailed technique in the beginning have greater practical value for later sessions; otherwise an inordinate amount of time would be spent on just doing an induction each session. It is invaluable to record your inductions and provide the recording to your clients to speed up the conditioning process and to provide them a means of getting comfortable even in your absence.

A second variation on the progressive muscle relaxation technique involves the same conditioning or association principle. By using a countdown, that is, associating a number to each muscle group (e.g., "10 … relax your feet … 9 … relax your calves and shins …") as part of the process, in later sessions you can simply count downward in the established sequence and each number can trigger the associated relaxation response for that particular muscle group.

A third variation of the progressive muscle relaxation technique is called the "Deep Muscle Relaxation" technique. In this technique, the sequential progression through the body is the same, but clients are additionally instructed to deliberately tense the muscles of the specific group under consideration. Instruct them to hold the tension in the muscles for 10 seconds or so and then to release it. The obvious relaxation of the muscles is both immediate and substantial. Try this yourself: make a tight fist, and hold it tightly for 10 or 15 seconds. You'll quickly notice your hand getting warmer, then tingly, and after a short while it can actually begin to shake with the exaggerated tension you

create. When you just can't hold the tension in your fist anymore, let go and allow your hand to relax. Feel how relaxed the muscles are? Now imagine how you would feel if you did that with every muscle in your body. The relaxation can be quite profound. This is an especially good technique for very concrete people who need direct and immediate experience of the contrast between tension and relaxation and also for those who generally have difficulty relaxing. The tense–release protocol works, in part, because physiologically, when a muscle tenses, it must relax before it can tense again. The muscle enters what is called a *refractory period*. You can even preface the "sure success" of this technique with this explanation of muscle physiology to clients. (What you don't need to tell them, however, is that the refractory period lasts only a fraction of a second.)

The variations of the progressive muscle relaxation technique are among the easiest and most effective inductions to perform. One word of caution, though. Most people I know who use hypnosis tend to use inductions that they find personally pleasing. I recommend you do inductions with clients' needs in mind and not according to which work best on you. With each induction you learn, it would be wise to consider for whom the induction would likely be perfect and for whom it would likely fail. For example, progressive muscle relaxation focuses people on their body. Thus, using this body-oriented technique with individuals in pain or with those who have a disturbed relationship with their body is not generally recommended. Can you see why?

Relaxed Scene Experience

This technique involves offering suggestions to clients to experience themselves in some special place where they can feel relaxed and secure and can enjoy a general sense of well-being. As you describe details of that special place, clients can experience getting increasingly absorbed in the suggested sensations of being there.

To begin, you can directly ask clients if they have a special place, either real or imagined, where they like to go to relax, escape from the daily stresses, or simply be comfortable. If they can provide such a place, then feeding back to them suggestions to experience the soothing characteristics of that place may be used in the induction. A second possibility is for you to choose a place for clients that you're reasonably confident will be a relaxing place for them, such as a garden or a meadow. This is a potentially hazardous choice to make blindly since you cannot know clients' experience of the place you've chosen unless you ask. If you choose the place for them, it is important to ask, "Have you ever been to [e.g., the beach, the mountains, a beautiful garden]? How would you describe your experience in being there?" Asking for feedback in this way limits the possibility that you may take clients to a place you enjoy but they do not. Of course, nonverbal feedback from clients is also valuable as you progress with your induction, but that develops after you have already

begun rather than employing a preventive approach before you begin. A third possibility is to avoid the mention of a specific place at all in your induction process, using contentless process suggestions to facilitate the experience. I'll say more about this latter alternative shortly.

In providing the details of the special place to clients, you can use the same or similar sensory-based terms they use in describing their experience of that place. This can allow them to get more deeply absorbed in the suggested experience since you're using the details they have already told you are significant. Providing additional suggested experiences in other sensory modalities can round out the induction and allow for a fuller experience of being in that place for the moment. The more involvement clients have in the suggested experience, the more dissociated a state they are in, detached from the immediacy of current goings-on elsewhere, allowing for a more meaningful hypnotic experience.

The following is a sample of a content-filled relaxed-scene experience induction. The suggestions all relate to the experience of being at the beach and begin with visually oriented suggestions, which then lead into auditorily and kinesthetically oriented suggestions:

> … Sometime in your life you have had the experience of being very near to the ocean and seeing it in all of its beauty and vastness … and you can begin to see the ocean in your mind's eye now … huge and mysterious, and for as far as you can see the ocean covers the earth … and way out on the horizon you can see distant ships and boats that sail the waters … and you can see and hear the rolling waves in front of you as they gently and rhythmically lap up on the beach … and you can even hear them as they softly roll back into the ocean … and the gentle sound of the waves is so soothing a sound … and you can feel the cool ocean breeze on your face … so refreshing and so relaxing … soothing and calming you so deeply … the smell of the salt water is an especially compelling part of being at the beach … as is the feel of the soft sand beneath your feet.…

Whatever special place you happen to use, whether a beach, a forest, an art museum, or any place in which clients find comfort, that place is inevitably full of sensory delights you can use to ease them into hypnosis. Use as much sensorily descriptive language as you can to facilitate a full experience for them. The more sensory details you provide that fit, the more they have to associate themselves to that place. Beware, however, that the more detail you provide, the more you may unintentionally provide content suggestions that don't fit.

The preventive solution is to use process (contentless) suggestions for the relaxed scene experience. When you provide few or no details at all, clients must provide their own in response to your general suggestions, thus greatly reducing the likelihood of mismatches. A disadvantage to the process form of this induction, however, is its briefer, more repetitious nature. Without the details of the experience, there is considerably less to talk about.

A contentless or process-based version of the relaxed scene induction might be worded as follows:

> As you continue to sit there comfortably with your eyes closed, you can let your mind drift back to the pleasurable memory of some special place, perhaps a special place that you've been to where you felt so good … so comfortable and secure and happy … or perhaps a place that you'd like to create and go to where you can fully sense how very peaceful you can feel inside when you are there … and you can allow yourself to go to that place right now, in your mind … you can feel yourself there, feeling the comfortable feelings you'd like to feel there … and you can notice the specific sounds of that relaxing place, soothing you … and you can see in your mind the images of that place, noticing how pleasing this special place is to you … and you can feel so good there.…

Going on and on about the sensory details of that place is possible without your having any idea where the special place is your clients chose. Anywhere they can feel comfortable is sufficient for this technique to be effective. Notice in the previous sample the suggestion for "a place you'd like to create and go to." In the event clients don't have a special place in their experience where they felt good to go to (a common issue in working with people with a history of abuse), they can then imagine creating such a place. That "safe place" can be a very helpful tool in later sessions beyond hypnotic induction (Covino & Pinnell, 2010; Rhue & Lynn, 1993).

Eye-Fixation Techniques

If not the oldest, certainly one of the oldest techniques for inducing hypnosis is the classic "eye-fixation" method. Popularized in movies, and often employed by classical practitioners, this technique involves having clients fixate their gaze on some specific spot or object (Barabasz & Watkins, 2005; Nash, 2008b; Weitzenhoffer, 2000). The focus can be on virtually anything: a spot on the ceiling or wall, the clinician's thumb, a dangling watch or crystal ball, a fireplace, a candle, an aquarium, an hourglass, whatever. Anything that holds clients' attention long enough for them to respond to the concurrent suggestions for relaxation will suffice in this technique.

As they stare at the stimulus, suggestions are offered encouraging them to notice every observable detail and that while fixing their gaze they can experience their eyes growing more relaxed and even tired. There is a little bit of trickery in this technique when done properly; clients' eyes should be elevated in their sockets as they stare at the stimulus, which then allows physiology to work in the clinician's favor. Eyestrain naturally occurs, and thus clients will, in fact, experience the heaviness and tiredness in their eyes just as the clinician has suggested. But they naturally attribute the sensations of fatigue to the

clinician's suggestions, not physiology, and as a result the clinician's credibility can rise.

An eye fixation induction method might be worded as follows, delivered permissively and contentlessly:

> As you listen to the sound of my voice, you can let your eyes search the room and find some spot or something that can be of particular interest to you right now … And when you find that particular object you can let your head begin to gently drop down while you allow your eyes to look upward toward that object … That's right … And now you can continue to look at it, and you can notice every detail about the way it looks … and as you continue to relax and look at it, have you noticed how tired your eyes are becoming? … And as you focus your eyes intently on that object.… Your eyes can grow more tired, your eyelids can seem to become heavier and heavier … and as soon as you realize that it takes too much effort to keep your eyes open, you can let your eyelids slowly drop down … and as they drop down you can drop into a very comfortable state of physical and mental relaxation.…

Commenting on clients' blinking, pacing your words to the eye blinks, and even modeling eye closure can further enhance your suggestions for eye closure. If after a reasonable period of time (don't hurry) they still have not closed their eyes, you can either switch techniques or simply suggest they close their eyes in a relatively direct way, such as, "You can close your eyes … now." If you still do not get eye closure, you can ask clients what they are experiencing: "You haven't closed your eyes yet, for some reason … and as you become aware of the reason … if you'd like you can tell me that reason … and thereby make it even easier for you to get comfortable …" Or, as another alternative, you can match clients by encouraging them "to keep your eyes open … as you learn something meaningful … with eyes wide open to the positive possibilities …"

Personally, I am not a fan of the eye-fixation technique, but it is so commonly used by so many I thought it necessary to include it in this text. In that way, you can be in a position to decide for yourself what is useful and what isn't. Why am I not a fan of this approach? Eye closure may take a while to get as a response with some clients and so can unnecessarily become a battleground in the "test of wills" between client and clinician. Older literature has often devoted a great deal of consideration to what you should do when an inordinate amount of time has passed and clients have still not closed their eyes, generally recommending treating it as resistance, analyzing it, and confronting it. I find it much easier to just suggest eye closure and get on with the rest of the induction process.

Even with their eyes open, clients can still be in hypnosis, as discussed earlier. Keen observation will tell you this and perhaps save you needless self-doubts or confrontations over whether they are experiencing hypnosis "properly."

Counting Methods

Counting methods of induction generally involve counting downward, implying "going down" deeper into hypnosis, and in between numbers steadily offering suggestions of relaxation and comfort (Erickson et al., 1976). At first, the slower and more detailed the process of suggesting focus and comfort between numbers, the better. As in the progressive muscle relaxation techniques, clients can become conditioned through experience and posthypnotic suggestions to need fewer and fewer suggestions between numbers until deep hypnosis can be accomplished with just a simple countdown.

This technique is popular because of its simplicity, evidenced in the following sample:

> In just a moment I'm going to begin counting downward from the number 10 to 1 … and as I count slowly downward you can relax a little more deeply with each number I say … and when I eventually reach the number 1 … you can begin to discover how easily you can experience yourself as very relaxed and comfortable … and I'll begin now with the number 10 … relaxing comfortably and breathing in (timed with the actual breathing)… and out … at a rate that's comfortable for you … and 9, relaxing even more comfortably, feeling the relaxation grow a little more with each moment that passes … and 8, feeling so much more at ease … and 7 times more comfortable than you were just a couple of minutes ago … and 6 … I can think of half a dozen good reasons to be even more comfortable … 5, etc., etc., 4, 3, 2, 1.…

A variation of the counting method involves having clients do the counting out loud slowly downward from 100 while the clinician intersperses suggestions of relaxation. Furthermore, the clinician can offer the suggestion that when clients "soon discover it takes too much effort to first remember and then say the next number," they can "stop counting and go even deeper into hypnosis." Rarely will you encounter someone who continues to count below the number 80.

A variation on the same theme is to complicate matters a little by having clients count backward by 7 from 1,000, or some comparably inconvenient numbers, as you offer suggestions for relaxation. This ends up requiring so much mental energy that it is a relief to clients to be able to stop counting and just drift into hypnosis.

The "As-If" Method

Theodore Sarbin was one of the leading social role theorists advocating the view of hypnosis as a "believed-in imagination." In one of his last published articles, he described the "hypnotic induction as an invitation to act 'as if'"

(Sarbin, 2005, p.125). He wrote, "Some inductions are explicit in conveying the request to act 'as if' you are reading a good book or watching a movie.' The sentences are sufficiently ambiguous to allow for interpretations that are guided by prior and concurrent beliefs" (p.125). He went on to say:

> Human beings, within limits, construct their worlds. Our constructions of reality depend upon the skill to function at various "as if" levels. This skill makes it possible to distinguish between self-reports that reflect ordinary perception ("I heard my mother calling me"), imagining ("It is as if I 'heard' my mother's voice"), and metaphor ("I heard the voice of conscience"). This hierarchy of hypothesis-making skills liberates human beings from the constraints of the immediate environment. With this "as if" skill the subject can interact both with observable events and with fictively constructed events that may be spatially distant and temporally remote. (p.126)

Paul Watzlawick was one of the key developers of strategic therapy. In a classic paper called "Hypnotherapy Without Trance" (1985), Watzlawick related the as-if paradigm to our expectations and eventual experience, establishing a basis for hypnotic induction and even the production of complex hypnotic phenomena:

> Nowhere does the as-if nature of our world become more starkly obvious than in the mechanism of self-fulfilling prophecies, whose clinical importance we barely have begun to appreciate. By behaving as if something were, or will be, the case, a truly reality-transforming fiction is introduced or, in other words, creates its own reality. What seem to be the basic laws of our reality are turned upside down: Imagined effect produces concrete cause; the future determines the present; the prophecy of the event leads to the event of the prophecy. (p. 13)

Generally a good method for more "difficult" clients, the as-if induction technique involves no direct suggestion to clients to respond in a particular way but rather to act as if they were responding in the way suggested (Edgette & Edgette, 1995). The suggestions to respond as if provide a one-step removed request rather than a direct demand. The extra distance between suggestion and response can reduce whatever need to resist the clients might have, making it easier for them to move in the direction of a fuller participation. For example, one might begin the as if induction by saying, "You can arrange yourself in a comfortable position as if you were going to relax deeply … and you can close your eyes as if you were going to focus inwardly … and you can focus on your breathing as if you were going to let your body become more comfortable." Suggesting that clients act as if they are comfortable, relaxed, thinking about a happy moment, or whatever, can pave the way for them to experience the effects of the suggestions without having to comply with any

real demands being made. In terms of the outcome, where the acting as if ends and the reality of hypnosis begins is ambiguous since the responses are virtually identical (Sarbin, 1997; Spanos & Coe, 1992).

INTENSIFYING (DEEPENING) TECHNIQUES

The formal, structured deepening techniques presented in this section have traditionally been used immediately after the formal induction is performed to intensify clients' experience of hypnosis (Gibbons & Lynn, 2010). The traditional models of hypnosis, which view clients' hypnotizability as the primary factor in successful hypnosis, have placed a greater emphasis on depth of hypnosis than does the more interpersonally based utilization approach (Barabasz & Watkins, 2005). Just how deeply in hypnosis do clients need to be? A deeper hypnotic experience isn't necessarily a clinically more successful one, so generally you only need an experience deep enough to be effective. Simply put, if clients are only lightly engaged yet integrate and apply what you offer, it was deep enough. Achieving deep hypnosis may not always be necessary, but it can allow for certain possibilities (e.g., fuller dissociations, more nonvoluntary responses, and easier generation of complex hypnotic phenomena) that make a mastery of deepening techniques necessary.

The Descending Stairs (or Elevator) Technique

In this deepening technique, clients are encouraged to imagine (see, hear, and feel) themselves at the top of a flight of "special stairs" or on a "special elevator" (Barabasz & Watkins, 2005; Watkins, 1987). As they imagine going "down the stairs slowly one step at a time, you can go down even more deeply into hypnosis." Or, "as you pass each floor while you gradually descend in the elevator, you can experience yourself going even more deeply into the comfort of hypnosis." Here's a brief sample of how this technique might be worded:

> I wonder whether you can imagine yourself standing at the top of a set of very special stairs, the stairs of relaxation … and as you see and even feel yourself at the top of the stairs … you can be very comfortable … knowing you are going to become even more profoundly relaxed as you prepare to step down into deeper comfort … and you can take the first step down … and as you take a step down the stairs of relaxation, you can step down into an even deeper state of focused and comfortable experience … you can relax so very deeply … And now you can take another step down, going even deeper into a very comfortable, profoundly absorbed state of mind and body … and then you can take another step down going even deeper.…

Each step down is emphasized both verbally and with tone of voice as a "step down deeper" into hypnosis. It is a good idea to make sure beforehand

that clients don't have any negative associations to going downstairs (e.g., childhood spankings in the basement) or riding in an elevator. If they do, then you would of course use a different deepening technique.

Compounding Techniques: Verbal and Manual

In the previous chapter, I discussed chaining suggestions, a technique also called *verbal compounding*. As you may recall, verbal compounding involves the tying of one suggestion to another according to the generic formula, "As you X, you can Y." For example, "As you close your eyes, you can take in a deep, relaxing breath." Besides smoothing the delivery of your suggestions by giving them a natural flow, verbal compounding also serves as a deepener by continually building new responses onto the foundation of past responses, thereby intensifying the hypnotic experience. Here's a brief sample:

> As you arrange yourself in a comfortable position, you can allow your eyes to close … and as you allow your eyes to close, you can take in a few deep, relaxing breaths … and as you take in a few deep, relaxing breaths, you can begin to notice your body growing more comfortable … and as you begin to notice your body growing more comfortable, you can begin to be aware of your thoughts slowing down …. and as you begin to be aware of your thoughts slowing down, you can remember a time when you felt excited about learning something new … and as you remember a time when you felt excited about learning something new, you can realize how easily you can absorb new ideas.…

Manual compounding involves the tying of verbal deepening suggestions to some suggested physical experience. It generally takes the form of offering suggestions for going deeper into hypnosis while experiencing physical sensations that reinforce the deepening suggestions. For example, assuming permission has been obtained to touch clients, you can gently push downward on their shoulders while suggesting "you can feel yourself sinking even more deeply into comfort." Or, following an arm levitation where they have experienced a nonvoluntary raising of a "weightless, floating arm," you can suggest, "As I slowly and gently drop your arm and hand back down to your side, you can drop slowly and gently even deeper into hypnosis." The physical sensations of "down" from the push down on the shoulder or the arm and hand dropping can amplify the verbal suggestions of "down" and make the experience a more profound one as a result.

The Mind's Eye Closure

I had previously been hypnotized quite a few times and found the experience comfortable, but it wasn't until I was exposed to this particular technique that I experienced deeper hypnosis and an appreciation for the nonvoluntary aspects of deeper hypnotic phenomena. (The full story is told in Yapko,

2011a). This technique involves offering suggestions to imagine the presence of a "mind's eye," defined as the part of the mind remaining active in thinking and imaging even as the body relaxes. By offering suggestions similar to the eye-fixation suggestions of the "eyelids getting heavy" for the "mind's eyelid," clients can slowly close out stray thoughts and images as the mind's eyelid closes and thereby have a deeper experience. It might be worded as follows:

> … Just as you have physical eyes that can see the world around you, you have an inner eye that we can call the "mind's eye" … and it can continue to actively see images and process thoughts even as you relax deeply … and you can think of your mind's eye as having an eyelid … and like your physical eyes your mind's eyelid can relax and gradually grow more tired and heavy, and it can begin to drop … and as it begins to close it slowly closes out stray thoughts and stray images and can leave your mind perfectly quiet and open and free to experience whatever you'd like … and it's closing more and more … and your mind grows more quiet, more restful … and now your mind's eye can close … and close out any stray thoughts or images allowing you to focus on how relaxed and attentive you are becoming.…

This technique can be an effective way of "turning off" much of the distracting or even unpleasant internal dialogue called rumination that goes on continuously in many of us, thereby making deeper hypnosis easier to accomplish.

Silence

Silence can be a useful deepening technique if used skillfully. Following an induction, suggestions can be offered to the effect that clients can now "have some silent time to enjoy the deep relaxation of hypnosis and the wonderful quiet inside and as you enjoy the silence you can deepen your level of comfort."

You may wish to preface the period of silence with an indicator of how long you will be silent (e.g., "You can take 60 seconds of clock time to enjoy a silent period during which you can deepen your relaxation even more …"), or you may instead suggest that clients signal you following the silence when they are ready to proceed with the session.

It is almost always a good idea to give some protective suggestion to clients in the form of an "anticipation signal" so when you begin to speak to them again after a period of silence your voice will continue to soothe rather than startle them. During the period of silence they can be so absorbed in their internal experience that they forget anyone else is even there and startle when you begin to speak again. An anticipation signal can prevent that from happening.

Here's a helpful hint: the use of silence as a deepener can also provide you with an opportunity to compose yourself and think of what the next step in the treatment plan is. In other words, it is a prime time in the process for

clients to go deeper into hypnosis while you figure out what you'd like to say and do next.

Posthypnotic Suggestion and Reinduction

This deepening technique, also called *refractionation*, is the deepening technique of choice with clients whose attention spans are diminished by their symptoms. That includes individuals who are deeply depressed, are highly anxious, are attention deficit, and are in pain. Refractionation can help such clients build a better attention span.

The technique involves doing a brief induction and then giving clients, already in some degree of hypnosis, a posthypnotic suggestion that "the next time and each next time we do hypnosis together you can go into hypnosis both more quickly and deeply." They are brought out of hypnosis and then, after brief discussion about their experience, are invited to go back into hypnosis, ideally going into hypnosis more quickly and deeply as suggested. The procedure is then repeated at least a couple more times, but each time for just a little longer. In this way, clients start to build focus and maintain it for longer and longer periods of time.

Some clinicians establish a *cue word* or *cue symbol* that experienced clients are to use as a rapid means for entering hypnosis. Building such a cue simply allows for less induction time and more time to use the hypnosis therapeutically. Thus, the use of posthypnotic suggestion and reinduction as a deepening technique is a useful one, with the qualification that if a cue is used it be one that is more gentle and respectful than a harsh command to sleep or a degrading finger snap. The best cues, in my opinion, are the most subtle ones, such as a gradual change in your voice to the voice qualities associated with your "hypnotic voice." The association to entering hypnosis in response to the use of your voice in a particular way allows a gentle transition from one style of interaction to another. Once clients have become experienced with entering hypnosis with you as a guide, such experiences can serve as a foundation for future experiences. In fact, making use of their previous hypnotic experiences is one of the conversational approaches to induction discussed in the next chapter.

SUMMARY

This chapter featured some of the most common and useful formal, structured methods for inducing and deepening the experience of hypnosis. Anything that focuses individuals' attention and facilitates feelings of comfort and well-being can be used as an induction technique. Those few presented here are intended to provide a foundation on which to build.

Practicing these techniques will allow you to develop the ability to deliver them in a smooth, flowing way. Choppiness is distracting and reflects uncertainty, an unsettling experience for clients looking for expert guidance.

Just as there are no clear dividing lines between the different levels of hypnosis, there are no clear dividing lines between the stages of hypnotic interaction; for example, what has been identified as a suggestibility test in this book does not have to exclusively be a suggestibility test. It may also serve as an induction or a deepener. The inductions can be employed as suggestibility tests or deepeners, and the deepeners can be suggestibility tests or inductions. For the sake of clarity in presentation, I have put the various techniques in the categories I did, but you can allow yourself the flexibility to use whatever will work when you need it.

FOR DISCUSSION

1. Should the clinician perform inductions he or she doesn't personally like? Why or why not?
2. How might a clinician find out whether he or she is moving too quickly or slowly for the client?
3. With what specific client populations should each of the inductions and deepening techniques listed in this chapter generally not be used? Why?
4. What experiences of acting as if you felt a certain way have you had, and with what results?

THINGS TO DO

1. Practice each of the techniques in this chapter on your classmates, shifting your style from person to person. What feedback do you get?
2. Research other approaches to hypnotic induction, and briefly outline each.
3. Develop a list of words and as many alternative words for each you will likely be using frequently in doing hypnosis. Include words such as *focus, remember*, *imagine, relax,* and *deeper*.

CHAPTER 18

INFORMAL, CONVERSATIONAL STRATEGIES OF HYPNOTIC INDUCTION

The formal, structured hypnotic inductions presented in the previous chapter are based on the general assumption that the experience of hypnosis is distinct from other forms of subjective experience and can be induced through some special, if not arbitrary, process. While most in the field readily acknowledge that hypnosis can occur spontaneously and a ritual of induction is unnecessary for hypnosis to occur (Kihlstrom, 2008; Wagstaff, David, Kirsch, & Lynn, 2010), many practitioners continue to employ ritualistic induction procedures that provide a coherent structure for distinguishing hypnotic from nonhypnotic interaction. It is both an advantage to use such rituals because of their clearer template and a disadvantage for their imposing an impersonal technique to which clients must try to adapt. As Zeig (2011) pointed out, hypnosis cannot be imposed. Rather, it must be elicited from within the client. Clearly, there are many ways to do so effectively.

When clients find a way to respond to a counting method, for example, they are demonstrating an ability to get absorbed despite the absence of relevance for the numbers as a source of personal meaning or comfort. After all, what's so engaging about counting numbers? Yet the counting methods, and other such ritualized techniques, actually work with many people, probably for the reasons Kirsch (2000) offered when he described the role of expectancy in responsiveness and further suggested that an induction is whatever clients think of and expect an induction to be. It's important to remember, however,

that there are brilliant and experienced experts who suggest hypnotizability matters more than social and cognitive factors, who don't believe hypnotizability is significantly modifiable, and who believe that hypnotic procedures should not vary across individuals (Barnier & Council, 2010; Spiegel & Spiegel, 1978/2004). Thus, your own beliefs about the nature of hypnosis are the key determinants of what you will do and how you will do it.

The Ericksonian or utilization approach to hypnotic induction (Erickson, 1958, 1959; Erickson, Rossi, & Rossi, 1976) rests on assumptions different from other models about the subjective experience of hypnosis, the qualities of hypnotic induction, the capacity for hypnotic responsiveness, and the goals in even doing hypnosis. These assumptions have a paradoxical effect: they add both greater complexity and simplicity to employing clinical hypnosis.

IMPOSING VERSUS ELICITING HYPNOSIS

In the utilization approach, hypnosis is viewed as a natural experience occurring routinely in people rather than a "special state." In adopting this perspective, one of the tasks of the skilled clinician is to first recognize hypnotic responses as they naturally occur in the course of ongoing therapeutic interaction and then build on them meaningfully in a spontaneous and conversational manner (Lankton & Matthews, 2010). Another of the tasks is to organize hypnotic processes around the unique attributes of clients, adapting the approaches to their subjective style of relating, thinking, and behaving. Rather than saying, "I'm going to name body parts while you focus on relaxing," as in a progressive muscle relaxation technique, an example of an invariant approach that requires clients to try to adapt themselves to the clinician's chosen technique, instead the utilization approach strives to elicit from within them the images, internal dialogue, feelings, and behaviors that are personally meaningful and engaging as the basis for the induction and therapy. Zeig (2011) described the process this way:

> Initiating hypnotic induction is a little like fostering love. One cannot elicit an emotional state, such as love, by intoning, "Go deeply into love." Similarly, one does not elicit hypnosis by commanding a passive patient, "Go deeply into trance." Note a key word in the previous sentence, *elicit*. Hypnosis is elicited, not induced (despite the label "induction").… The hypnotherapist establishes conditions that allow the patient to bring forth previously dormant trance components. (p. 45)

In other words, the skilled clinician can elicit responses by employing hypnotic patterns of communication that capture clients' attention and focus them on experiences that will be personally and therapeutically significant. The instructions to clients in the conversational (Ericksonian, naturalistic,

utilization) approach to hypnotic induction are typically more individualized, permissive, indirect, and process oriented than other, more technique-oriented approaches. Furthermore, there is typically not as clear a beginning, middle, or end to the induction compared with the clearer transitions from phase to phase of the hypnosis session found in the more structured approaches of the previous chapter.

The spontaneity required to "accept and utilize" clients' unique way of being, the foundational principle of the utilization approach, makes it undesirable to ritualize or standardize the practice of clinical hypnosis. For some, the lack of a rigid structure to the methods is a turn-off. For others, that same trait is a turn-on, an exciting challenge of how to elicit a meaningful and therapeutically effective hypnotic experience in a particular person in a specific context. Implicit in this approach is the role of clinician as both guide and initiator of what is to happen. The clinician's responsibility to clients is amplified in the utilization approach because they are regarded as capable of a meaningful hypnotic experience if a more individualized and flexible approach is employed. This stands in marked contrast to the belief that successful hypnosis is more about clients' level of hypnotizability than the quality of the therapeutic alliance or the flexibility of your approach.

The stimulus for the hypnotic experience in the utilization approach is in the conscious and unconscious associations (e.g., cognitive, sensory, emotional, physiological) the clinician elicits in the client through his or her suggestions. This perspective also differs considerably from the view that the power of the hypnotic suggestion is contained in the suggestion itself rather than in the way clients relate to it. Such a view allows for the scripting of hypnotic procedures that some clinicians will read verbatim to their clients. The scripting of hypnosis parallels the current trend toward the manualizing of therapies, or the empirical "validating" of a therapy, as if what's therapeutic is inherent in the technique rather than in individuals' response to the technique. Any therapy can be iatrogenic or antitherapeutic for some people who respond in idiosyncratic and negative ways. That's the key reason keeping a focus on individuals and tailoring approaches to them is emphasized throughout this text as a means for minimizing negative responses. Which specific associations of client experience will be triggered by your words cannot be predicted with certainty. Observing and using clients' responses as they arise will, of necessity, temper your approach.

FROM CONVERSATION TO CONVERSATIONAL INDUCTION

Securing and maintaining clients' attention is a beginning point for the hypnotic interaction. Talking about the issues that brought clients into treatment,

telling engaging yet instructive stories that parallel their experience, and behaving in unexpected but goal-directed ways are three common techniques for securing their attention. As clients' focus is narrowed to the clinician, the clinician can begin to build on their responses by first acknowledging them and then suggesting directly or indirectly that these responses can serve to gradually expand their range of problem-solving resources. When the clinician notices hypnotic responses building (e.g., absorption, changes in breathing, a fixed posture, muscular tension dissipating), he or she can begin to engage clients in the process of induction and deepening through the naturalistic techniques described in this chapter.

The transition from routine conversation to hypnotic induction is a subtle one in this approach compared with the more formal, "OK, close your eyes now and let's do some hypnosis," approach. Induction is usually but not necessarily explicitly announced to clients as a new phase the therapeutic interaction is entering but can instead be eased into as a natural part of the progression of treatment, once their expectation is established that they will experience hypnosis. Whatever clients spontaneously do during this time is accepted and utilized as part of the process. Thus, the implicit message is, "What you're doing right now is what will allow you to deepen your experience further." Behaviors that seem "resistant" such as fidgeting or interrupting are accepted and used as the basis for further suggestions, redefining them as acceptable and even useful responses.

The skilled manipulation of the nonverbal components of the clinician's communications is always a major factor in doing hypnosis, but in the utilization approach it is especially so. Deliberate changes in your tone of voice, your quality of eye contact, posture, and other analogical communications while shifting into an induction may serve as potential associations to entering hypnosis in this as well as future experiences. For example, using your slower, quieter "hypnotic voice" selectively will predictably encourage hypnotic responses; that is, communicate an invitation to clients to enter hypnosis without having to say, "Now I'm doing hypnosis." Those voice qualities became associated with hypnosis when you used them from the very first induction onward. This is but one example of how you can obtain hypnotic responses from people without directly asking for them. Your body posture, gaze, and breathing patterns are further examples of potential patterns on which to build associations to generating hypnotic responses. Table 18.1 offers further hints for performing naturalistic inductions more skillfully. Most of these have already been discussed at various times in the text, while others will be introduced here.

The methods for guiding people into hypnosis described in this chapter are reliable. They have a structure as well as a vehicle for delivering the structure, but they are more spontaneous and conversational than more formal approaches. Each involves narrowing clients' field of attention to their

Table 18.1
Conversational Induction Principles

Utilization of clients' reality (past or present)
Accessing questions to absorb and direct attention
Use of yourself as a model
Notice and amplify responses
Verbal chaining: "As you X you can Y"
Presuppositions: How to do X, not whether
Interspersal of suggestions
Framing responses (incorporation)
Shift in delivery style (nonverbal)
Orient to internal experience
Elicit and guide associations

inner experiences, specifically the associations triggered by your suggestions. Resources long dormant in them can be reactivated and mobilized in a goal-directed fashion, and new experiences that expand their range of capabilities can be purposefully encouraged.

CONVERSATIONAL (NATURALISTIC) INDUCTIONS

Using Past Hypnotic Experiences as the Foundation

The recognition of hypnotic experiences arising spontaneously in people allows for a smooth transition into the induction phase of hypnosis. All people have had naturally occurring or spontaneous hypnotic experiences that may not necessarily have been thought of as being hypnosis yet can be identified as such by the clinician. Describing common experiences of absorption across daily life experiences paves the way for using them as personal examples of hypnosis to build an induction upon in treatment. For example, "highway hypnosis" is the common experience while driving a car of being absorbed in thought and paying little or no conscious attention to the act of driving yet arriving safely at your destination by means of a complex series of automatic behaviors. Similarly, getting lost in a good book, caught up in a movie, fascinated by a lecture, and enthralled by a conversation are examples of evolving the kind of selfless absorption typical of hypnosis that are found in daily life. Describing such situations and reminding people of their capacities for such experiences becomes the basis for encouraging such responses to arise through the conversational induction.

Many people, however, have experienced formal hypnosis at one time or another, perhaps in educational or clinical contexts, where it was clear that

hypnosis was occurring. These past formal experiences can be the foundation for building new hypnotic experiences upon when the induction encourages a multidimensional connection to them.

Thus, the induction method of "Using Past Hypnotic Experiences" involves two general categories of previous hypnotic experiences on which to build: (1) Informal experiences with hypnosis, specifically the everyday hypnosis experiences people have during the course of normal daily living; and, (2) formal experiences with hypnosis, specifically the previous times clients experienced hypnosis positively. Either approach may be offered in either a process-oriented or content-filled structure, described later in this section.

Building on Informal Experience In the first approach of building on previous informal experiences with hypnosis, the phase of attentional absorption typically involves some preinduction discussion about the nature of hypnotic experience while exploring clients' associations to hypnosis (Gibbons & Lynn, 2010; Nash, 2008b). At some point during the discussion, the clinician can begin to model increased attentiveness, immobility or catalepsy, and slowed breathing and can begin to hypnotically describe one or more natural situations in which hypnosis occurs. Such situations might include the boredom of long drives, absorption in a good book or movie, relaxing during a massage or hot tub, enjoying daydreaming, or any other situation in which they have had the direct experience of being experientially absorbed.

The nonverbal shift from a normal pace and conversational tone of voice to one that is slower, quieter, and more meaningfully articulated is fundamental to guiding persons into the suggested memory of that natural hypnotic state they have experienced (Lankton & Lankton, 1983). Through the absorption in that memory, hypnotic responses—namely, the ideodynamics—naturally begin to occur in the here-and-now, which the clinician can notice, accept, and utilize according to the "As you experience this, you can experience that" chaining formula described earlier. Clients do not need to close their eyes to experience hypnosis, but the clinician may want to suggest eye closure by offering a direct or indirect suggestion to do so. The following is a sample of how this technique may be worded, using a previous informal hypnotic experience of reading with indirect suggestions in the form of embedded commands to obtain specific responses:

> You mentioned earlier you enjoy reading a really good book … I really enjoy reading, too, especially when I have some quiet time all to myself … a time for quiet when I know I won't be interrupted.… As you know from your own experience … it's such a luxury to have some time … to sit quietly … and not have to do anything … a time you can let yourself relax so deeply … sitting in a way that is so comfortable … and you know what that's like, too … and how easy it is to sit quietly … just thinking … without moving for what can seem like a long, long time … and I like to

> read books that encourage you to experience yourself differently … you know the kind I mean … that absorb you in different ways of thinking … different ways of feeling … books that allow you to expand yourself and change in beneficial ways … and you probably know quite well what I mean … how your mind can be so active in learning while your body gets even more comfortable with each page you turn … and when you get too comfortable to keep on reading, you can close your eyes and drift off … and I'd like to tell you about a book I read that may have special meaning for you.…

This induction starts out conversationally and then turns to a sharing of personal experience that clients can relate to so the clinician can build rapport while simultaneously slowing down and building associations to entering hypnosis. Then the shift takes place from "I" to "you," with an emphasis on clients' experience building into a relaxed and focused state through the tonal emphasis on suggestive phrases. As they become absorbed in the memory of relaxing and learning while reading, their responses can start to build in the current context and become the basis for transitioning into whatever therapy during hypnosis is to be done.

This sample is obviously a content-filled one, providing details specific to the experience of reading. A process-oriented approach could also be employed, of which the following is an example:

> Can you think of a time when you were so involved in some deeply absorbing experience that you detached from and even forgot to notice things going on around you? Every person has had experiences like that where … you find yourself immersed in some activity … and as you relax … and remember … and think about that kind of an experience … you can easily remember a specific experience like that … one that was especially pleasant … where you were so into it … you could lose track of time … and forget to notice outside sights and sounds … and only your sensations and thoughts were important … and you could feel so wonderfully relaxed … and isn't it nice to know you can be so wrapped up in your thoughts … that people's voices fade away … and you're alone with your thoughts … and feelings of comfort … and it's at times like that … and like this … that you can learn something important.…

In this sample, the process of becoming absorbed in sensation and thought is described, but no details of a specific context triggering such experiences are provided. Rather, clients provide those details for themselves when the suggestion is offered to choose a specific experience to recall that was pleasant.

Building on Formal Experience In the second approach, building on formal experiences with hypnosis, the typical preinduction phase discussion can focus clients' attention on the range of possibilities hypnosis allows and how

previous experience with hypnosis can make future experiences easier, more satisfying, and more successful. It seems worthwhile to reiterate a point made earlier about exploring the nature and quality of clients' previous hypnotic experiences. If clients had a positive and meaningful experience with hypnosis, then the clinician has a solid, positive base on which to build. However, if they had a negative experience with hypnosis, one that was unsuccessful at least or hurtful at most, then the clinician must exercise caution to refer to that negative experience either as little as possible or in a detached way in the course of performing hypnosis. Questioning clients about techniques used and identifying the personal, situational, and interpersonal variables operating negatively at the time can save you from unwittingly duplicating a previous negative experience.

If clients have had a positive experience with hypnosis before, a content-filled approach to the use of the formal hypnotic experience can involve engaging them in providing an ever-slowing, detailed account of the experience. This approach usually involves a large degree of interaction as the induction progresses, with the clinician simultaneously questioning clients, suggesting possible responses, and building on their responses as they occur. The mechanism of induction is structurally the same as in using informal previous hypnotic experiences: as the person becomes absorbed in the memory of hypnosis, the ideodynamic responses associated with that memory evolve in the here-and-now. The clinician notices, accepts, and utilizes those responses, building hypnotic responsiveness toward the goal of the interaction. The following is an example of this induction approach:

Clinician: You mentioned earlier that you experienced the comfort of hypnosis before, didn't you?

Client: Yes. A couple of years ago I saw a doctor who did hypnosis for another problem I was experiencing.

Clinician: As you begin to think back now, can you recall how soothing and calming an experience hypnosis was?

Client: Yes, I do remember feeling really relaxed. I didn't expect to be able to hear the doctor's voice, but I did. I wasn't sure I was hypnotized, but it felt really good.

Clinician: That's right … the experience of hypnosis can be so relaxing … so soothing … and you can remember how you were sitting then, can't you?

Client: I guess so … (readjusts position)

Clinician: That's right … sitting very comfortably now … and do you remember how good it felt to breathe deeply and close your eyes?

Client: (deep breath, eyes flutter closed) Yes.

Clinician: And you can probably recall what you heard then that allowed you to relax so deeply, can't you? And what did you hear that reminds you that you can be comfortable?

Client: Just the doctor's voice … telling me to relax deeper and deeper … that it was as if I was floating …

Clinician: That's right, and you can remember what it's like to have that light, comfortable feeling everywhere in your body.

In a sense, clients act as their own hypnotist, giving themselves the same suggestions from the past in the present; thus, the clinician's role is a simple one of amplification. Clients already know how to experience hypnosis, have already defined it as helpful, and remind themselves in detail of the relaxed, floating nature of the hypnotic experience and, in so doing, unconsciously recreate it. By framing the interaction as a "discussion" about past experience rather than a set of current demands to which clients must respond, the suggestions to enter hypnosis are less direct, more permissive, more natural to the interaction, and the issue of resistance is therefore largely avoided.

To use this kind of an approach in a process-oriented way, the interactional dimension of the induction can, if desired, be eliminated. The following is an example of the use of formal previous hypnotic experiences offered in a contentless way:

> You mentioned earlier that you had an experience with hypnosis before that was a very relaxing and helpful one. If you'd like, you can begin to recall now many of the details of what that experience was like … remembering how your body can be so comfortable … how your breathing can begin to slow down … and I wonder whether you'll remember how comforting it can be to simply sit quietly … in a comfortable position … while you listen to someone describe some ways that you can begin to experience yourself differently … and do you recall how good it felt to close your eyes? … and the memory of relaxing so deeply is still a part of you … even if you haven't had time lately to notice it … and isn't it nice to rediscover something familiar and calming that can help you? … and perhaps you can remember the room you were in when you learned how to feel good in this way … you can see the furniture and you can hear the sounds of that place, and as you remember the details of then … you can feel comfortable about that experience right now …

The context in which clients had their previous formal experience with hypnosis is not known to the clinician, nor does it need to be as long as the clinician is certain the experience was, in fact, a good one for clients by their own description. The clinician elicits and guides clients' memory of a successful experience with hypnosis from the past into the present.

Making use of clients' previous experience with hypnosis, whether formal or informal, is one of the easiest yet most effective induction and deepening processes. It is a spontaneous, loosely structured approach that generates little resistance because as it gets under way "we're not talking about now, we're talking about then." The extra psychological distance makes a difference in encouraging an increased comfort in developing hypnotic responsiveness.

Building an Internal Focus

The experience of hypnosis has been described as one involving absorption, an intense concentration on some stimulus to the exclusion of others. Usually, but not always, the absorption is internally directed. Guiding clients into hypnosis implies having them selectively attend to the clinician, specifically becoming absorbed in the subjective associations triggered by their suggestions.

In routine interaction, therapeutic or otherwise, people are expected to be more externally oriented and responsive to the other person. When one lapses into brief episodes of self-absorption in social situations, it is considered rude, inattentive, or disinterested or is even considered evidence of a passive-aggressive hostility. Yet such episodes of internal absorption are normal, natural, frequent, and to be expected. In fact, in learning and doing hypnosis, one of the difficulties some students encounter is developing the ability to stay externally focused on clients' responses as much as possible. They sometimes lapse into an internal focus as they stew about what to say next. If you are too internally absorbed while doing hypnosis, you are going to miss a great deal of important nonverbal information communicated by clients during the process. Maintaining an attentive external focus on clients is the best way for the clinician to maintain a connection to them by noticing and incorporating their responses into the induction.

The induction process of building an internal focus involves offering "pacing" statements of what *external* stimuli clients are currently aware of, coupled with "leading" statements describing *internal* responses the client may begin to develop (Gilligan, 1987; Grinder & Bandler, 1981). This can be done in any ratio of pacing to leading statements the clinician judges to be useful. In other words, how many externally oriented suggestions of experience you offer for every internally oriented suggestion of experience is dependent solely on clients' responsiveness.

The assessment can be made early on in your interaction with clients as to how internally or externally absorbed they tend to be in the course of routine interaction. An internal or external orientation in relating to the world is generally a fairly stable characteristic of an individual yet can and does vary markedly from situation to situation. Internal or external focus exists on a continuum, and no one can be exclusively one or the other in a fixed way. Assessing clients' direction and degree of focus is usually a simple process of observing how the person communicates about their experience. Do they see themselves as responsible for their problem, or are they victims of evil forces beyond their control? Are they sensitive to others' feelings and perceptions, or are they blissfully unaware of others' feelings and reactions to them? Are they easily distracted from your interaction by external but routine things like a phone ringing or a plane flying overhead? Are they generally insightful about their experience or somewhat clueless about what's going on "in there?" Observations along these lines of assessment can allow you the opportunity to formulate an induction and intervention that will more likely be effective.

Once you've assessed how internally or externally focused clients are at the time you would like to begin your induction, you can make the judgment as to what ratio of external paces to internal leads you think would be effective, modifying it as necessary according to their response. Some clients are already so internally focused at the beginning point that you don't have to have much of an induction beyond, "You can go into hypnosis now." Others may be so externally focused that they may require five or even ten external pacing statements before a single internal leading suggestion is offered.

As the induction progresses, fewer and fewer externally oriented statements are made while more and more internally oriented suggestions are offered. The following is provided as an example of this induction process with someone deemed moderately externally oriented at the start of the induction. To help you distinguish them, an (e) follows each externally oriented suggestion and an (i) follows each internally oriented suggestion.

> You're sitting in that chair (e) and you're listening to me describe the experience of going into hypnosis (e) … and as you continue to look at me (e) you may notice the feel of the chair underneath you, supporting your body comfortably (e) … and as you notice the chair you can hear the phone ringing somewhere (e) … and isn't it soothing … to know you don't have to answer it and so you can let yourself relax easily (i) … and you can notice the wall behind me with its interesting pictures (e) and you may notice the objects on my desk (e) … and as you look around the room you can hear the routine sounds of this environment (e) and you can hear the sound of the world busily going on around you (e) and you can feel so good in realizing that your body can grow more at ease (i) … and your mind can begin to drift back to a pleasant memory (i) … and as your mind drifts back you can feel the texture of the chair on your fingertips (e) and as you notice how that texture feels you can also hear the things I have to say (e) … and as you listen you can become aware of a certain memory (i) … one that you feel is important that you'd like to re-experience and learn from (i) … a memory that may remind you of something you'd like to know now (i) …

In this example, the induction starts with a series of statements that are pacing what clients are currently aware of, feeding back aspects of what they are doing, then offering a general statement of what they can experience. The ratio of paces to leads shifts as the induction progresses, gradually leading clients into reexperiencing an important memory.

You may notice the use of sensory-based terms in visual, auditory, and kinesthetic modalities. A way to further individualize the process is to deliberately choose the sensory modality of internal experience you want clients focused on. Many of the problems clients present clinically can be described in terms of internal or external focus on a particular sensory modality. The most obvious example is pain, which can be thought of as an intense internal

awareness on the kinesthetic level. Management of pain may, as you might predict, involve shifting clients' focus from internal to external or from the kinesthetic modality to another one.

Most hypnotic inductions involve building an internal focus, each according to a different method. This induction provides the barest of frameworks for helping clients experience hypnosis, since all that is provided here is a structured description of the process as shifting clients' focus from external to internal experience. Which externals and which internals you use in what combination in which modality and in which style and structure allow for a huge range of possibilities. How successful your induction will be, as always, is determined primarily by how well you have assessed clients' response style and how well you can spontaneously adjust your approach according to the feedback you get.

Metaphorical Inductions With Embedded Suggestions

In the earlier section on using past hypnotic experiences as an induction strategy, I described how putting a little psychological distance between the desired experiences "now" by focusing on experiences from "then" can allow for greater responsiveness. Metaphors generally describe some other person's (or animal's, or thing's) experience at some other time in some other place. The use of metaphor is an even less direct induction approach and so may be viewed as less personally threatening to clients. As Jay Haley (1973) wrote:

> When a subject resists directives, one way to deal with the problem is to communicate in terms of an analogy. If the subject resists A, the hypnotist can talk about B, and when A and B are metaphorically related, the subject will make the connection "spontaneously" and respond appropriately … the analogic, or metaphoric, approach to hypnosis is particularly effective with resistant subjects, since it is difficult to resist a suggestion one does not know consciously that he is receiving. (pp. 26–27)

In *Webster's Encyclopedia of Dictionaries*, a metaphor is defined as "a figure of speech which makes an implied comparison between things which are not literally alike." Metaphors in the therapeutic context may include anecdotes, jokes, analogies, or any other form of indirect communication that conveys a meaningful message to clients on conscious or unconscious levels. Metaphors provide an opportunity for clients to learn from others' experiences, allowing them to identify, to some degree, with the characters, issues, and resolutions of the metaphor.

Learning from the experience of others throughout recorded history has allowed human civilization to evolve. You do not have to experience something personally to know about it, and if you are reflective or thoughtful about others' experiences you can understand and benefit on a personal level from

the lessons embedded in their experiences. In growing up, you heard and read classic fairy tales like *Snow White* and *Cinderella*, and you learned something from them about human nature. Your parents' stories about their childhood taught you about families and growing up. In reading books of all kinds, you gradually learned about different societies, different lifestyles, as well as different types of relationships. Even in watching television and movies, your sense of involvement in the story allows you to experience vicariously similar feelings and events as the characters in the story, indirectly broadening your range of experience and developing resources that may be drawn upon at some future time.

The popular use of metaphorical approaches in clinical treatment is a relatively recent development, catalyzed primarily by the work of Milton Erickson. His fascinating and often simple teaching stories were able to capture his patients' interest on a conscious level, while his embedded suggestions allowed patients to form new unconscious associations that could serve them in therapeutic ways (Rosen, 1982; Yapko, 2001a; Zeig, 1980b). More will be said about metaphorical approaches to therapy in the next chapter, while this section focuses on the use of metaphor in the induction phase.

You may recall the earlier discussion about how clients' symptoms may be viewed as metaphors of their experience. Clinicians have historically been trained to take clients' communications and "read between the lines" to uncover their "real" meaning relative to individuals' symptoms and overall experience. Once the real meaning has been uncovered, the clinician's role has been to offer interpretations and, through the interpretations, to generate insights that would lead to new perspectives and, ideally, more adaptive behavior in clients. In other words, while clients are communicating a meaning on a conscious level, it is understood that there are deeper unconscious meanings being communicated simultaneously if only one is perceptive enough to detect them. The multiple-level communication on clients' part has historically been responded to by the clinician in a clear, single-level interpretation.

Erickson considered such interpretations as too simplistic, too reductionistic, to accurately reflect the complexity of any piece of human experience. Erickson also thought that if clients could communicate on multiple levels, why couldn't the clinician do the same? Furthermore, Erickson had great faith in unconscious resources and thus had a strong interest in developing techniques that could make practical use of them. Erickson's greater utilization of the unconscious in the treatment process was also out of respect for the integrity of those he worked with. If individuals' unconscious mind defensively kept some information out of their awareness, such as in repression, was it necessary and respectful to bring the information into their conscious awareness? Erickson thought not and believed that insights may even impede the therapeutic process by keeping individuals restricted to a narrower cognitive

level of existence, widening the gap between intellect and emotion rather than bridging it. Haley (1973) described Erickson's views on these issues this way:

> Although Erickson communicates with patients in metaphor, what most sharply distinguishes him from other therapists is his unwillingness to "interpret" to people what their metaphors mean. He does not translate "unconscious" communication into conscious form.… He seems to feel that the depth and swiftness of that (therapeutic) change can be prevented if the person suffers a translation of the communication. (pp. 28–29)

Among the safest of alternatives to working consciously with potentially reductionistic or even trite interpretations is the therapeutic metaphor. Relating a story that can capture clients' conscious interest while allowing them to learn new ways of thinking, feeling, and behaving at deeper levels is a respectful and flexible way of engaging them in treatment. In the context of inducing hypnosis, metaphors can focus clients' attention on an experience that is interesting, while the clinician embeds suggestions for desired hypnotic responses into the story's framework.

When you formulate a metaphor for the purpose of induction, it helps to know something of clients' personal interests, values, and hobbies. Metaphors built around things that are already a part of their lifestyle are more likely to capture and maintain the person's interest. Of course, things of an intrinsically fascinating nature will also serve well. The broader the base of knowledge and experience the clinician has, the more sophisticated one's metaphors can be. The metaphor as an induction method can introduce clients to other people's experiences, can help them build a rapport with the clinician, can build an identification with the characters of the story, can confuse them as to why the story is being told and thereby stimulate a search for meaning and relevance, all while building the internal focus and receptivity helpful for the subsequent intervention (Zeig, 1980b).

Perhaps the easiest metaphors are those that begin with "I had another client in a similar situation to yours.…" When you describe the experience of some previous client, individuals can come to identify with that person and also build confidence in your experience in dealing successfully with such problems. If, for example, a client presented the complaints of excessive stress and poor self-esteem, the induction might go something like this:

> You're describing to me how uncomfortably tense you feel much of the time, and I guess it isn't often … or often enough … that you take the time to relax … and I'd like to tell you about a client I worked with not long ago … a woman who is not unlike yourself … with many responsibilities … and she came to me feeling so tense … so unsure of herself … uncertain how she could continue to function on too little sleep with the burden of too much to do … and she didn't know that she didn't have to feel that way … and she wanted to feel good … feel relaxed … and when she sat in that chair you just

> happen to be sitting in, too … she actually took the time to notice how comfortable that chair is … and then she let herself take in some deep breaths … and she seemed to just let go of the everyday concerns … and she could listen to me comfortably … while her mind could begin to wander … and the memory of the last time she could relax deeply helped her realize she knew how to relax so deeply … and that she could and would take more time for being comfortable … simply because she deserved it … and she learned how to re-evaluate her priorities … and she learned how to say no more comfortably to extra tasks she really didn't have time for … and she learned.…

This example is simply an induction starting point for leading into more metaphors about possible ways to start to build confidence and better manage stress. As an induction, it begins by matching clients' concerns and then building the identification with another similar client who had a positive experience in some ways that may be of interest and helpful. There is ample room to maintain rapport by incorporating clients' spontaneous responses into the metaphor.

To illustrate a metaphorical induction tailored to clients' specific interest, the following example of a metaphor was developed for a person who likes to decompress by watching television:

> You like to watch television when you can take the time to unwind … and watching television can certainly be an entertaining way to spend some time relaxing … and I like to watch TV sometimes … but not nearly as much as some people … there's someone I really think you should know about … who, like you, likes to watch television more than almost any other form of entertainment … and as a good means of relaxing you and quieting your mind … and he says he can learn a lot about life and a lot about people by watching television … and there was a show on once that he told me about … that he watched to be entertained … that did much more than only that … it taught him a lot about himself … he didn't know that in that show there was going to be an opportunity to have a pleasant learning experience … sometimes you discover important things in the most unexpected places … and he learned something important … because in that show he watched, there was a man who … not unlike you … felt very badly about a problem he just couldn't seem to resolve.

In this example, television as a learning device and a source of relaxation is used as a vehicle to lead the client into hypnosis. At the point where the example stops, the clinician can go into one or more metaphors about the client's problem and its potential resolution.

Almost any experience can serve as a metaphorical induction into hypnosis when the qualities of that experience are defined as absorbing, comforting, and meaningful. Engaging individuals' attention on the content of the story allows for deeper messages embedded in the story's structure to stimulate their unconscious associations. Metaphors, because of their indirect style, create the possibility for a response, but whether one is obtained is dependent

on the way the metaphor is introduced (called the *framing* of the metaphor), the appropriateness of the metaphor for individual clients, and the degree of rapport maintained throughout its telling. The metaphor must be introduced as potentially significant, either by some direct introductory remark such as, "This other client of mine I'd like to tell you about is someone I think you could learn something valuable from …" or indirectly through the meaningful tone of your voice and quality of eye contact. The relevance of the metaphor was discussed earlier and generally should involve something of interest to clients.

Storytelling seems to have become an art on the decline. Television and the internet have saturated our society and placed us in the role of passive viewers of experience. Meaningful, face-to-face interactions between people become fewer in frequency as more of us "talk" to others in chat rooms and through text messaging. Developing a skill in storytelling is fundamental to developing a balanced approach to the practice of clinical hypnosis. Accumulating a broad array of instructive stories and practicing telling them is most helpful. One way to do that is to reread the classic fairy tales, fables, and old Greek and Roman myths, for they are excellent starting points for rediscovering the wisdom of the ages that's been handed down in story form.

The specific dynamics of meaningful metaphor construction could fill volumes and so can be only superficially presented in this book. For more in-depth consideration, see the work of Philip Barker (1985), Rubin Battino (2002), Peter Brown (1993), George Burns (2001, 2005, 2007), D. Corydon Hammond (1990), Stephen Lankton (2008), Stephen and Carol Lankton (1983, 1989), and Bill O'Hanlon (1987, 2009), to name just a few of many good resources.

Induction Through Negative Suggestion

You may recall the discussion of negative suggestion structures, presented in Chapter 15. Negative suggestions, when used skillfully, can encourage positive responses in clients through their paradoxical effect (Seltzer, 1986). They can do so in part because of the transderivational search and ideodynamic processes and in part because of their acceptance and utilization of client resistances. Resistance as a factor in the hypnotic interaction is discussed in greater detail later in Chapter 23; suffice it to say here that few clients are blindly obedient to the suggestions of the clinician. Instead, each client maintains a sense of control, internal homeostasis, and autonomy through the rejection of input (typically interpreted as evidence of "resistance" according to the clinician's way of thinking) even when the input is obviously intended to benefit clients.

In clients for whom control is a sensitive personal issue, a tendency to respond negatively and in a contrary manner as a reliable response pattern is frequently evident. If the clinician says, "It's day," clients responding in an oppositional mode disagree and say, "It's night." Such polar responsiveness is not necessarily aimed specifically at the clinician but rather may be a general

response pattern these individuals use everywhere or nearly everywhere to their own detriment. You have undoubtedly experienced such people's ability to stir up conflict wherever they go yet who often puzzle over why people don't relate to them very well. The need to defend against others' input to maintain what must be a precarious internal balance is a basis for such response styles. Someone with a greater sense of self can maintain a strong sense of personal identity even while selectively incorporating ideas from others.

In the hypnotic interaction, the negative response style can be accepted and utilized in the service of hypnotic induction and utilization. The principle underlying the use of negative suggestions is, "fight fire with fire." When negative suggestions are offered to critical, controlling clients, they can naturally reject them and respond in an opposite way. Knowing their tendency to respond in such a contrary manner, the clinician can deliberately use negative suggestions they will reject to get the opposite responses that are actually desired. Beware, though, for offering negative suggestions will seem an obvious and demeaning trick unless they are offered in a subtle, congruent, and meaningful manner.

Imagine, for a moment, a client sitting opposite you who is anxious, uncertain about you and your hypnosis techniques, uncertain about himself, and struggling to maintain a sense of personal control. The following example of an induction through negative suggestion might be a useful one to employ:

> You've come here looking for help with your problem because you don't like the way you are feeling … and you can feel differently … but I don't expect you to know that yet … for right now … it's important to know … you can and perhaps even should reject anything and everything I say … you don't have to listen to me or anybody else … you have the right to ignore anything you want to … especially if it's different than what you already believe … you can't be expected to be open enough right away to listen and learn what you came here to … at least not yet … and for now you can't be expected to change in a meaningful way … until you've had the opportunity to continue feeling badly a while longer … so don't listen to me … and don't give yourself the chance to feel more at ease … and you can continue to squirm in your chair … I don't want you to relax here or now … I don't think there's any reason for you not to continue fidgeting … so don't sit still and don't let your muscles relax … and don't let your eyes close even when they can get so tired of staying open … and some people feel good when they know they don't have to listen to me … talking about all the ways you don't need to notice opportunities to change in a comfortable way … and don't allow yourself the comfort of relaxing deeply … because you might start to feel better … and it's much too soon for that to happen.…

In this example, suggestions for relaxing and changing were offered in the negative framework, "Don't do this." To clients deemed negative and resistant, on the surface no demands have been made so there really isn't anything

to consciously resist. On an unconscious level, the ideodynamics associated with the transderivational search process assure you of some degree, however small, of responsiveness to your suggestions on which to build. You have to think of relaxing not to relax, you have to think of change to think of not changing, and so on. The key is to incorporate into the process whatever specific spontaneous responses arise in these individuals, redefining them as cooperative. For example, if you accept clients' fidgeting instead of labeling it a resistant behavior, it can be encouraged. By encouraging it, you define it as something useful in the interaction, even though their intention was to not cooperate. This technique of using negative suggestions to utilize clients' resistance is one more way of responding to resistance in addition to those described in Chapter 23 on nonideal responses from clients to your methods.

The use of negative suggestions in the induction phase of hypnotic interaction is intended to use clients' resistance to help guide them into hypnosis. At some point, clients realize that all your suggestions about not relaxing, not letting go, not focusing internally, and so on, have had the indirect effect of facilitating the attainment of hypnosis. This can be, and usually is, a positive turning point in the relationship. Clients have now had their experience guided by the clinician, and not only did they survive it but also actually found it pleasant and relaxing. The relief that comes from not having to fight to maintain a sense of control can have a profound impact on clients, who have now started to learn from their own direct experience that they can still be in control without having to fight others off through negativity. This initial hypnotic experience can then serve as a basis for future hypnotic experiences conducted in a more positive suggestive framework.

Induction Through Confusion Techniques

The process of eliciting hypnotic experience involves creating a somewhat dissociated condition in which clients' unconscious is able to respond with a greater degree of autonomy than in the usual "waking" state. Confusion techniques are especially effective for facilitating dissociation and, therefore, hypnosis (Erickson, 1964a; Gilligan, 1987). Confusion techniques are among the most complex hypnotic patterns to master because they are, well, *confusing*.

Human beings generally hate to be confused. Confusion creates an unpleasant internal state that motivates them to clear up the confusion. Frequently, people are so motivated to resolve the confusion that they will jump to erroneous conclusions just to have a conclusion, any conclusion. Confusion techniques deliberately disrupt clients' everyday mental set to increase the likelihood of a suggestion getting in without the usual scrutiny (Otani, 1989). Because people do not like to be confused and will hold erroneous, even self-destructive, ideas rather than allow an issue to remain unsettled, the clinician faces the task of dislodging old, hurtful thought patterns to build more adaptive ones. When you are certain about something, how likely are you to change your attitude

Table 18.2
Assumptions Regarding Confusion Techniques

People value clarity and understanding
Confusion, or lack of clarity, creates an unpleasant internal state (i.e., dissonance)
Dissonance motivates striving to attain understanding
Wanting to attain understanding motivates a search for meaning and an increased receptivity to satisfactory (even if incorrect) explanations
People's behavior is patterned, and carrying out familiar patterns is most comfortable
Blocking the carrying out (i.e., interruption) of familiar patterns requires generating a novel response
The time span required to generate a new response is a period of amplified responsiveness to external cues

about it? Not very likely, for the more certain you are about an idea or behavior, the more stable and thus resistant to change you are in that domain. When you aren't sure, though, you are much more likely to take in what others say and adopt their recommendations for as long as they seem credible to you.

Confusion deliberately causes uncertainty and thus paves the way for a change in attitude and behavior. When people are confused, they stop. And then they develop an internal focus (a spontaneous hypnosis?) as they quickly sort through everything they know to resolve the confusion. While they are so preoccupied consciously with making sense of something, the unconscious is more readily available for any suggestion that will reduce the dissonance. In a nutshell, that's the mechanism of confusion techniques. The relevant principles are listed in Table 18.2.

Confusion techniques can take a variety of forms but generally fall into one of two categories: pattern interruption strategies and overload techniques. Pattern interruption techniques involve saying or doing something to deliberately interrupt individuals' routine response style in some area. One may strive to interrupt people's experience of a thought, a feeling, or behavior, or some other pattern, depending on the desired outcome. Disrupting the pattern and shifting the person onto a "new track" can effectively break the old pattern long enough to let a new and potentially helpful experience have a meaningful impact. Interrupting individuals' symptomatic pattern may be accomplished in a variety of ways, as listed in Table 18.3.

Changing some of the environmental variables surrounding the pattern (e.g., where, when or with whom the person "does" the symptom), shifting the sequence of the pattern's subcomponents, altering others' responses to the pattern, exaggerating or emphasizing the implications of the pattern, surrounding the desired responses with confusing irrelevancies, and building new associations to the pattern through outrageous or incongruent clinician responses are just a few techniques available to interrupt client patterns. Furthermore, the clinician can use gestures to interrupt clients, can dramatize with nonverbals

Table 18.3
Pattern Interruption Strategies

Confusion
Surprise, shock
Humor
Reframing
Double-binds
Paradox, symptom prescriptions
Task assignments, behavioral directives joining clients' frame of reference (utilization)
Confrontation
Hypnosis and hypnotic phenomena
Ordeals
Metaphors
Amplifying polarities
Externalizations

clients' position, and can use language patterns that are so ambiguous or are even blatantly in violation of normal speech syntax that clients become entranced through trying to figure out how he or she can behave in such an unpredictable, even odd, way.

The following is a transcript of Milton Erickson using a confusion technique on a patient experiencing pain (in Haley, 1967, p. 152). Part of Erickson's strategy involved the use of language patterns violating the routine patterns of meaningful communication while embedding therapeutic suggestions for comfort at a deeper level. The client's normal flow of consciousness is interrupted to accommodate Erickson's unusual speech patterns, allowing his unconscious to absorb meaningful suggestions in a beneficial way:

> [… some family member or friend] … knows pain and knows no pain and so do you wish to know no pain but comfort and you do know comfort and no pain and as comfort increases you know that you cannot say no to ease and comfort but you can say no pain and know no pain but know comfort and ease.…

While the client's conscious mind focuses on trying to make sense at a cognitive level out of a linguistic mess, at the feeling level the associations triggered by the suggestions to feel good and feel no pain allowed Erickson's patient the desired comfort.

This transcript also demonstrates elements of the other form confusion techniques may take, namely, overload techniques. Overload as a means for creating confusion can take the forms of excessive repetition and sensory

overload. In the previous transcript, Erickson's repetition of the suggestions to feel comfort and feel no pain are so frequent and so excessive while embedded in other confusing statements that it would be difficult to resist each and every one on a suggestion-by-suggestion basis. Repetition of suggestions is extremely tiresome and even boring for clients' conscious consideration, yet repetition is a well-known enhancer of unconscious learning processes. Embedded in a confusion technique, however, are suggestions that are clear and actually make some sense. These can stand out as if illuminated in neon compared with the confusing background and thereby draw greater attention and potential impact.

The other form of overload, sensory overload, involves so overloading the person's conscious mind with information coming in from multiple sources that it can't possibly keep up; as individuals struggle to stay consciously focused, the unconscious can respond to a greater degree. An example of a sensory overload technique is the "Double Induction" technique originated by Kay Thompson, Ray LaScola, and Robert Pearson (see Dr. Thompson's Frame of Reference section in Chapter 9) and described by Kay Thompson (2004a). With two (or more) clinicians simultaneously doing hypnotic inductions on a single client, the person may initially attempt to follow both clinicians' voices but quickly learns that it's simply not possible to consciously keep up with both for very long. Whatever information is offered that escapes conscious detection and analysis might still be incorporated on an unconscious level, and for the beleaguered and overloaded client surrendering the need to scrutinize when such scrutiny isn't possible, hypnosis may be a nice, relaxing place to escape to.

Sensory overload can involve the use of multiple (two or more) clinicians working on a single client or multiple stimuli (e.g., sounds, smells, sights) operating on different levels. If you do not have the luxury of another clinician around to try this technique, you can even make a general induction tape and play it during a session while simultaneously doing your more personalized approach "live." You can even suggest to your client, "You can listen to me … or you can listen to me." Such overload techniques can be especially useful in the treatment of individuals in pain (Yapko, 1988a).

Confusion techniques for the purpose of induction require that clinicians have a clear head, demanding that they know what they are doing at each moment. It also requires some dissociation on the part of the clinician (as well as the client) to keep from getting caught up in the confusion they are creating. One can build confusion around virtually any dimension of experience, from the days of the week ("You can relax on Tuesday but not nearly as well as on Wednesday and if you remember on Sunday how good it felt to relax on Friday you can remember one day on a Monday to take in a deep breath and …") to remembering ("How can one forget how good it feels to go deeply into hypnosis when one remembers that to forget what one remembers only reminds one to forget remembering the

Table 18.4
Categories of Confusion Methodologies

Cognitive	Temporal	Affective
Sensory	Role	Spatial
Relational	Identity	Behavioral

comfort and peace of remembering to forget what you've forgotten to remember about forgetting tension and remembering comfort …"). Table 18.4 lists the specific dimensions of experience at which one can aim confusion strategies.

By offering confusing suggestions in a manner generally regarded as meaningful, the clinician leads clients to search and find meaning at deeper levels. Confusion techniques are especially good for clients deemed highly cognitive who tend to intellectualize their problems or feelings. The intellect cannot keep up for very long with an abundance of irrationalities embedded with meaning, so overloads can shift intellectual clients onto a more affective level of relating.

CONCLUSION

The approaches to induction presented in this chapter are among the most spontaneous and effective means for inducing hypnosis in a naturalistic and collaborative way. Their inability to be scripted in a word-for-word manner is actually their strength. Hypnosis scripts may make clinicians feel a little less insecure about what to say, yet they are a reliable means for becoming more rigid and less creative in your work. Clinicians who develop skill in the use of these loosely structured and spontaneous approaches will have done so only through multiple sessions of practicing careful observation of client responses while developing the flexibility to turn each obtained response into one that further enhances the quality of the interaction.

FOR DISCUSSION

1. How are transderivational search and the ideodynamic processes operating in each of the inductions described in this chapter?
2. How does one's general internal or external orientation in relation to the world around us evolve? What implications for either mode of relating are there for doing effective hypnosis?
3. How does one "fight fire with fire" in everyday contexts? Give specific examples and describe the dynamics operating in each.
4. Should a clinician attempt to induce hypnosis in a client without first announcing his or her intention? Why or why not?

5. What is the basis for Erickson's claim that "out of confusion comes enlightenment"? Is confusion useful for facilitating change? Why or why not? Are there times in your own experience you have had an "Aha!" experience? Describe it.

THINGS TO DO

1. List 25 common everyday experiences where elements of hypnosis are evident. Outline a set of suggestions for each as if describing them were an induction procedure.
2. Have two peers talk to you simultaneously on two different subjects and try to follow each. What do you experience?
3. Describe to your class in as hypnotic a demeanor as you can (e.g., slowly, modeling absorption, using sensory descriptors) an ostensibly nonhypnotic experience in which you relaxed comfortably (e.g., riding a bike, hiking in the woods, sitting in a sauna). What is your audience's response?

CHAPTER 19

HYPNOTIC PHENOMENA
Eliciting and Utilizing Hypnotic Resources

The classic hypnotic phenomena defined and described in this chapter are the foundational ingredients for the therapeutic applications of hypnosis. Furthermore, they are the basic building blocks of all experience, differing in their everyday forms from their clinical applications only in degree, not kind. Although qualities of hypnotic phenomena are found in routine daily experiences, they are most dramatic to observe and experience when distilled to their essence as in structured hypnotic processes. It's important to appreciate from the outset in considering these hypnotic phenomena that they are not innately positive, nor are they innately negative in character. They can be assembled in ways that may help or hurt, depending on their associated content and the context in which they are applied. Simply put, the same hypnotic phenomena that can be used to resolve problems can be used to create them. More will be said about this important point later, particularly in relation to hypnotic phenomena and symptom formation.

The various hypnotic phenomena represent valuable but typically underdeveloped capacities of human beings. Each person is generally regarded as capable of developing these hypnotic phenomena to one degree or another in the formal hypnotic interaction because they are, in a sense, clinically structured amplifications of everyday experiences (Voit & Delaney, 2004). In fact, these capacities are a necessary part of our experience for us to function

in a normal, healthy way (Bányai, 1991). To claim that individuals cannot be hypnotized at all is questionable, for if they could not focus, remember, imagine, behave in automatic ways, and demonstrate other such hypnotic capacities, they simply could not survive. As we have seen, people differ markedly in their hypnotic talents, and some may have only marginal ability. But finding someone who can't experience any of these at all would be exceedingly rare.

When describing the various hypnotic phenomena, I will also describe examples of everyday contexts in which they naturally or spontaneously occur. People generally do not think of these random experiences as related to hypnosis, but they are structurally identical. When they occur, people tend to dismiss them lightly with some variation of, "Gee, that's kind of strange." No further thought is given them, because they seem to "just happen." The average person senses no participation in or direct control over the experience. This is a primary reason for acquiring skills with hypnotic patterns: Rather than having such potentially useful experiences remain random and seemingly beyond control, clinicians familiar with hypnosis can facilitate these experiences at will for meaningful reasons, helping clients and also instilling a greater sense of control in their lives.

The recognition that hypnotic phenomena occur routinely in people is, in most ways, unique to the utilization approach. In other models of hypnosis, hypnotic phenomena are generally considered manifestations of the separate and distinct state called "hypnosis." Even when others have claimed hypnotic phenomena are concentrated forms of everyday occurrences, the techniques used to obtain such responses have incongruously been only ritualistic and artificial. The utilization approach emphasizes a more natural and personally meaningful style for facilitating these responses. But, consistent with my desire to acquaint you with the range of possibilities, both structured and naturalistic approaches to eliciting hypnotic phenomena will be presented in this chapter. Clinical applications of these phenomena will be discussed in later chapters.

As you read each of the following sections, you might think of your own experience of that particular hypnotic phenomenon, specifically what happened and in what context. Discovering the everyday aspects of hypnotic experience can gradually allow you to notice and utilize more of the spontaneous hypnotic responses arising in your clients as you interact with them. In fact, a familiarity with everyday contexts where hypnotic responses occur is the basis for the naturalistic utilization approaches (Yapko, 2001a; Zeig, 1980b). The general approach involves finding and hypnotically describing routine situations in which the desired response is likely to naturally occur. The client can become absorbed in that suggested experience and may then naturally demonstrate the hypnotic phenomenon. It has long been known that simply imagining the occurrence of a physical movement can bring that movement about, what has been termed an ideomotor response (Arnold, 1946). T. X. Barber, Nicholas Spanos, and John Chaves (1974) wrote that hypnotic responses can be produced by imagining "a situation which, if it actually

occurred, would tend to give rise to the behavior that was suggested" (p. 62). Similarly, emotions, perceptions, and fantasies can be suggested that will also give rise to hypnotic phenomena.

HYPNOTIC PHENOMENA

Let's assume at this point in the clinical interaction you have interviewed the client, obtained the salient information you need to design and deliver a meaningful hypnotic experience, introduced hypnosis to the client and received an agreement to participate, oriented the person to hypnosis, performed an induction and deepener, established a response set, and now have a client who is attentive and awaiting your next move. Table 19.1 lists the hypnotic phenomena.

Here, then, are the classical hypnotic phenomena, presented in alphabetical order for easy reference.

Age Regression

Description Age regression is defined as an intensified absorption in and experiential utilization of memory. Age regression techniques take two general forms: (1) guiding clients back in time to some episode to reexperience it as if it were happening in the here-and-now, a process called *revivification*; and (2) simply having clients remember the experience as vividly as possible, a process called *hypermnesia*. In revivification, clients are immersed in the experience, reliving it in a close parallel to the way the memory was incorporated at the time it actually happened. They feel and respond from that past

Table 19.1
Classical Hypnotic Phenomena

Age regression
Age progression (pseudo-orientation in time)
Amnesia
Analgesia
Anesthesia
Catalepsy
Dissociation
Hallucinations (positive, negative)
Ideodynamic responses (ideoaffective, ideomotor, ideosensory)
Sensory alterations
Time distortion

Note: Value as building blocks: neutral

time as if it is not at all past but present. In hypermnesia, clients remain in the present while simultaneously recalling more vividly the details of the memory.

Most people have an intuitive understanding of how profoundly our previous experiences affect our current thoughts, feelings, and behaviors. Certainly, psychology has amassed vast amounts of information to substantiate the point. Consequently, age regression is one of the most widely used hypnotic patterns in therapeutic work. Age regression as a clinical technique provides an opportunity to go back in time, whether it be into the recent or distant past, to recall forgotten memories of significant events that can serve to help redefine individuals' self-view or to "work through" old memories to reach new and more adaptive conclusions. Memory is a process, not an event. Memory is based on subjective perception and is therefore malleable and dynamic (Kandel, 2007; Squire & Kandel, 2008). Memories can change in quality over time, as new experiences mingle with and affect older ones. Memories can be influenced intentionally or unintentionally because of their subjective and suggestible nature (Loftus & Hoffman, 1989; Sheehan, 1988, 1995).

In defining age regression as the intense absorption in and experiential utilization of memory, the everyday aspects of age regression can become apparent, for people drift into memories routinely. If a song associated with a high school sweetheart comes on the radio, the listener can become absorbed in the memory of that person and vividly recall things they did together and events taking place in their lives at that time. For a period of time, the rest of the world fades from awareness while the listener is deeply internally absorbed and focused on memories, even reexperiencing profoundly the feelings from that time in life.

Age regression is as commonplace as that kind of experience. Any cue that triggers individuals to go back in time to remember or relive some event is stimulating a *spontaneous age regression*. Looking at photographs, hearing a certain phrase, and seeing an old friend then becoming absorbed in the associated memories are all examples of routine age regressions.

Age regressions can be structured to engage people deliberately in some memory that seems to have relevance to the symptoms they are experiencing. People literally define themselves according to their memories, especially those that are of highly charged significant emotional events. Many symptoms do, in fact, arise because of how people have interpreted the meaning of past events, so exploring and addressing memories often becomes a critical part of treatment.

Age Regression Is at the Heart of the Field's Biggest Controversy I must now raise the issue that has been bitterly emotionally charged and divisive, not only in the field of hypnosis but also in the mental health profession as a whole. It has been known as the *repressed memory controversy*, the *false memory debate*, the *memory wars*, and a variety of far more inflammatory names. Unless you were in blissful oblivion somewhere during the latter half of the '90s, you were reading almost daily about high-profile court cases, reading op-ed newspaper articles, and hearing experts on television vigorously

arguing about the issue of whether presumably repressed memories uncovered through therapy in general and hypnotic age regression in particular should be considered valid (Loftus, 1993; Terr, 1994; Yapko, 1993a, 1994a, 1994b). While the controversy has died down a great deal as cooler heads—and solid research—have gradually come to prevail, there are still occasional flare-ups of new legal cases and clinical dilemmas involving the relationships among trauma, memory, and suggestibility.

There are many therapists who have been either academically trained or self-taught to believe that virtually all symptoms are necessarily a product of past experiences, especially past traumas. These most frequently involve a presumed childhood sexual abuse that needs to be identified and "worked through." Thus, if individuals are unable to recall any such memories of abuse that would account for the type and severity of their symptoms, the clinician holding this viewpoint makes the assumption that the traumatic memories have been repressed, that is, split off from conscious awareness as a psychological defense. It is further assumed that excavating the repressed memory is necessary for recovery (Blume, 1990; Fredrickson, 1992).

In searching for presumably repressed memories, the critically important questions are these: Are traumatic memories "locked away," and does finding the "key" with hypnosis or other memory recovery techniques open them up for accurate recall? Or are the techniques used for locating and retrieving memories themselves capable of contaminating or distorting memories without either the clinician or client realizing it? To go a step further, can a well-meaning clinician and an unwitting client even create complex and emotionally charged memories that seem genuine yet are entirely fabricated, called *confabulations*?

The answer to the first question is yes: there is evidence that traumatic memories can, in some rare instances, be locked away only to emerge much later (Brown, Scheflin, & Hammond, 1998; Spiegel, 2010). More common, though, is amnesia for specific details but a global knowledge of having suffered a trauma. Thus, presuming the presence of such repressed memories solely on the basis of symptoms that could be as readily caused by other means is a dangerous presumption to make. However, what can only be addressed—but not necessarily answered—is the question of the accuracy of such buried memories that resurface in response to suggestive interventions. These memories can be entirely accurate, partly accurate, partly inaccurate, and entirely inaccurate. Without objective evidence to corroborate a memory, there is no known technology for determining its veracity. *Hypnosis does not reveal the truth.* The fact that the memory surfaced during hypnosis, included more detail in the narrative, and featured a more emotional telling of the episode does not mean the memory is any more likely to be true. Neither does so-called truth serum or a lie-detector test, which is why information obtained through these tools of inquiry is not generally allowable testimony in most courts. Since a true recovered memory cannot be reliably distinguished from a confabulation, even by so-called experts challenged to do so in experiments, it becomes even more

critical for clinicians to minimize their potential contamination of a memory through the unwitting use of suggestion.

The second and third questions regarding the memory recovery techniques themselves distorting or even creating memories can both be answered with a firm yes. Memories have been shown to be highly responsive to a variety of suggestive influences both in and out of hypnosis (Heap, 2008; Mazzoni, Heap & Scoboria, 2010; Schacter, 2002). Can clients really come to believe they were abused when no such abuse ever actually occurred? Yes. Thus, Wester and Hammond's (2011) point that "it is not the use of hypnosis itself that is a problem with regard to memory issues, but rather the interview style and manner in which hypnosis may be used" (p. 257) is well founded.

Just to clarify and reinforce the key point of this section, this controversy revolved around suggested memories of abuse given to clients by the clinician when clients had symptoms but no recollection of any such trauma. If individuals know now and have always known they were abused, then the issue is moot: such memories can be believed and considered as reliable as any others.

General Applications of Age Regression In using age regression clinically, at least two general strategies can be employed, each giving rise to a variety of specific techniques. The first general strategy concerns the use of age regression to go back to negative or even traumatic kinds of experiences. The intention is to allow clients to explore the events, to release pent-up feelings (*catharsis*) while simultaneously providing new ways of looking at that situation (*reframing*) that may help them release or redefine whatever negative influences lingering from that experience still affect their life. In this strategy, either revivification or hypermnesia may be employed, depending on the clinician's judgment as to how immersed in or distant from the experience clients can be to receive maximum therapeutic benefit. For example, if a client felt rejected by his mother and feels worthless as a result, the clinician may want to take him back in time through revivification to relive one or more of the interactions critical in developing that feeling. This could be done by helping him to relive the feelings and reexperience the sights and sounds of that event while supporting him in expressing those feelings. Then, the clinician can focus him on dimensions of that experience previously unnoticed or disregarded. By adding new understandings and insights to the old memory, the clinician can help the client redefine the memory. For example, the client can be encouraged to feel loved and cared for by a mother who did, in fact, love him but was suffering with her own emotional limitations of one sort or another.

Reaching a new conclusion about an old experience can change your feeling about yourself quite dramatically. Having clients immersed in the experience allows for its powerful emotional impact. In contrast, if a clinician were working with a woman who had the terrible experience of being raped, putting her back in that intense situation through revivification is generally an undesirable alternative. She may be better helped through the more psychologically

distant technique of hypermnesia. In this approach, she can safely be in the here-and-now while working through the trauma of the past (Lynn & Kirsch, 2006; Spiegel, 2010).

The second general strategy of age regression is one of accessing and amplifying client resources and is compatible with and easily integrated with the first. The strategy involves identifying and making use of specific problem-solving abilities clients have demonstrated in past situations but are not currently using, unfortunately, to their detriment. Often, clients have positive abilities they don't recognize, and because they aren't aware of them and have a means to access them these abilities lie dormant. In using age regression, the clinician can help clients rediscover in their past personal experience the very abilities that will allow them to manage the current difficulties in a more adaptive way. For example, for clients who are complaining of difficulty in learning something new, the clinician might guide them back in time to a variety of past experiences of initially feeling frustrated in learning something and then showing how each frustration eventually led to mastery of that information and greater self-confidence in that area. This is an example of building frustration tolerance. Learning to get dressed, read and write, drive a car, and countless other experiences all started out being intimidating new experiences and later became routine, automatic abilities. Immersing clients in the past experiences of the satisfaction that came from mastering skills that initially seemed difficult can help them build a more positive attitude of accepting uncertainty as a normal part of the learning process and applying it toward the present challenges.

Approaches to Eliciting Age Regression Any pattern of suggestion that helps clients subjectively experience going back in time can be regarded as an approach to age regression. One general approach to age regression employs suggestions that involve the use of structured and imaginative imageries as the trigger to recapture past experiences. Other approaches involve more naturalistic, everyday approaches to immersion in memory. Either approach can be a good one, depending on clients' response style.

Patterns that make use of clients' imagination include the various "special vehicle" approaches such as a special train, plane, time machine, space ship, elevator, or other vehicle that can transport them back in time to the event under consideration. The special vehicle imagery is an artificial, concrete, and content-oriented means for structuring the regression suggestions and thus requires a considerable amount of detail to facilitate the process for clients. The following is an example of an age regression approach using a "special train" as the vehicle:

> … And now that you can experience yourself as comfortably relaxed … you can allow yourself the experience in your mind … of imagining going to a special train station … a train station unlike any you've ever experienced before … where the trains that run are so unusual in their ability to take you back in time … and you can go back in time … to important experiences you haven't thought about in a long, long time … and you can walk over

> to one in particular and see yourself climbing aboard this most interesting-looking train … and you can easily find your way to a seat that is so comfortable to sit in … so soft you can rest there … deeply resting … and then as you feel the train begin to move in a gentle and pleasant way … you can experience the distinct movement of the train's motion … going backward in time … slowly at first … then faster … building a powerful momentum … and as you look out the window … and see the events of your life moving past you like so many telephone poles you pass on the way, the memories of yesterday … then the day before … and the day before … and the day before … and all the days before … can drift through your mind as you go further and further into the past … when way back then becomes now … and then the train begins to slow down … and then it comes to a stop … and now you can step off the train to find yourself in that situation that was so important to you … and being in that situation now, you can see the sights, hear the sounds, and feel the feelings of that time and place …

At this point, a dialogue between the clinician and client may be initiated to elicit the details of the memory that is being reexperienced. Asking clients where in time they are, who else is present in the memory, what exactly is occurring, what they are thinking, feeling, or doing, as well as any other relevant questions can lead the clinician to better understand the experience and how clients incorporated it as a memory so that a differing perspective, one that may be more adaptive, may be offered as part of the therapy.

If clients know when a certain significant event occurred, the clinician can regress them back to that specific time. Often, though, they have no idea when a certain feeling, thought, or behavior started. In such instances, the clinician can offer some process-oriented suggestions, such as in the special train example in which no particular age or context for the regression were specified. In that example, it was left entirely to clients to choose an experience to focus upon as representative of their presenting problem's evolution. The clinician must ask clients to verbalize the details of their experience at some point so they can assist the client in having access to as much of the memory as possible and to determine where and when to intervene.

Whatever approach you choose to employ as the catalyst for the age regression experience, the use of more sensory details to associate clients encourages their greater involvement in the experience. To accomplish a more personally distant experience of the past event, suggestions can be provided that clients are present (dissociated) in the secure here-and-now, and it can be "as if you are watching a movie of an experience … and as you watch comfortably … you can learn something important from yourself over there.…"

More naturalistic approaches to age regression involve offering indirect suggestions to become engaged in memory without the formality of saying, "Now you can go back into the past." Patterns include asking accessing questions to orient persons to their past personal history and conversationally sharing learnings from past personal or professional experiences. Asking questions to orient persons to

their past experiences as an approach involves them in a search through their past to recall the appropriate events necessary to respond meaningfully. Such a search can start out as a more distant memory simply being cognitively remembered, but then skillful further questioning can begin to immerse clients in the memory to actually reexperience it. The following is an example of such a pattern:

Clinician: Can you remember your fourth-grade teacher? (Orienting the client to age 9 or 10)

Client: Sure, it was Miss Smith. As I recall, she was a really nice teacher. (Starting to remember that teacher and some associated childhood experiences)

Clinician: Fourth grade can certainly be an interesting time in one's life.… Many changes can take place in a person's thinking.… I wonder if you can remember which event of that time in your life was especially important to you? …

Client: Well, there was a time once when I got into trouble at school and my mother … (relates the story's details)

Clinician: Can you … see yourself clearly in that experience? … As you see yourself in that experience, you can remember how you felt, can't you? … And those feelings are feelings that are still a part of you … even though you haven't thought about them in a long while … and you can see the other people and how they look … how they are dressed … and you can hear what they say that is so important to you … and what do they say?

As the clinician asks the client to fill in the details of the memory, the client naturally becomes more and more immersed in it to the point of starting to reexperience it. Also, notice the changing of tenses from past to present, subtly shifting from what was to what is as a means of revivifying the memory. This type of regression is a routine part of many psychotherapies, particularly those that focus on the past as a means of better understanding and altering the present. Such gradual immersion in the memory is a smooth and natural approach for focusing on the past. The involvement becomes greater and greater as the clinician involves more and more of the person in all the sensory components of the memory to as great a degree as possible.

To make the experience of going back into the past less personally threatening, another approach involves the clinician indirectly facilitating regression by describing either his or her own relevant past learnings or the relevant past learnings of others. When the experience of others is described, an application of metaphor, clients naturally tend to project themselves into that situation, imagining how they would feel or act in that situation. Talking about the experiences of others as children, for example, can build an identification for the client on the basis of his or her own experiences as a child. Thus, the regression occurs indirectly through identification and projection, and clients can go back in time to recall or reexperience the relevant memories.

The following is an example of such an approach, offered to a client who felt guilty unnecessarily and unjustly about her parents having divorced when she was only 6 years old. The regression involves taking the client back to that time to reexperience the initial development of the irrational feeling that she was somehow responsible for her parents' divorce. This example stops before the point of making the hurtful decision and does not go into the actual redecision therapy for such a problem:

Clinician: Children are quite remarkable, don't you think?
Client: Yes, I do.
Clinician: Sometimes kids think the whole world revolves around them … like life is a universal game of peek-a-boo … that the whole world stops for a while … and goes away to someplace else … who knows where … maybe someplace really calming and beautiful … when the child closes her eyes and the world disappears … How well can you remember being a child … and closing your eyes … and wondering where everyone went? …
Client: I used to play hide-and-seek a lot as a child, and I can remember worrying sometimes I'd be all alone, that when I closed my eyes everyone would be gone and I'd never find them again … but, of course, that's just a child's silly fears.
Clinician: That's interesting, because a child I'm working with described that same feeling … she's almost 7 years old now, and she's feeling very proud of being in the first grade … excited and thrilled … the way almost all kids once were … you can remember that, can't you? … about being in school and learning to learn about how much there is to learn … and that there is a huge and complex world out there … a world much bigger than the world of a 6-year-old … but the 6-year-old doesn't know that yet … She still has to learn to read and write … about science and math … about adults and other kids … about falling in and out of love … and the 6-year-old's world is always changing and growing … but not so fast as she thinks … because part of her still thinks the world revolves around her … and that she can cause big things to happen … and she won't learn until she's older … that the world doesn't revolve around her at all … that she's just 6 … and, understandably, afraid of being alone …

In this example, the clinician is matching the part of the client that is feeling overly responsible at age 6 with the thoughts and feelings of another 6-year-old. When these are described in a way that can allow the client to recapture her similar thoughts and feelings, she can age regress in a more spontaneous and naturalistic way. Furthermore, the seeds for the subsequent therapy are being planted simultaneously when the therapist points out in a nonthreatening way the distorted perceptions of a 6-year-old. This can pave the way for

the client to eventually accept that her thoughts at that time might have been distorted also and may therefore be more easily transformed.

Other techniques for age regression include the following:

1. Affect or somatic bridging, where clients' current feeling or awareness is linked ("bridged") to the first time, or one of the first times, they had that same feeling or awareness ("… and as you continue to be aware of that 'abandoned feeling' you've described, you can drift back in time and recall the first time you ever had that same feeling") (Watkins, 1971).
2. Temporal disorientation, in which confusional suggestions are employed to disorient clients from "now" and reorient them to "then" ("What happens now and then is that remembering then now reminds you now of then when then is so important and when then becomes now because yesterday led to today and you can remember yesterday as if it were now because now and then remembering then as if it were now can be so important …").
3. Age progression and regression, in which clients are first guided into the future at which time they can remember the things that have happened in their past ("Look forward to the times that you can look back …"). By orienting to the future first, an even greater emotional distance is created from past experiences, making them easier to recapture and use therapeutically.

Age regression is one of the most widely used and beneficial applications of clinical hypnosis. The clarity of long forgotten memories that can be elicited and the power of constant, intrusive memories that can be restructured are common components of clinical work in general and the use of hypnosis in particular. Knowing the mechanisms of memory, including its strengths and limitations, is vital to sound clinical practice. If you haven't yet made a study of memory, I'd encourage you to do so before your next client walks in and says some variation of, "When I was 10, here's what happened to me…." Table 19.2 lists age regression strategies.

Table 19.2
Age Regression Strategies

Direct regression to a specific time or situation
Affect or somatic bridging
Imagery, special vehicle techniques
Indirect associational suggestions
Metaphorical approaches
Gradual regression
Temporal disorientation
Age progression and regression

Age Progression

Description In contrast to age regression's focus on the past, age progression is a utilization of projections of the future. Age progression involves guiding clients experientially into the future, where they may have the opportunity to imagine and experience the consequences of current or new choices, integrate suggestions at deeper levels, rehearse new patterns of thought, feeling or behavior, and, in general, obtain a greater overview of their life than a narrower focus on day-to-day living typically affords. You can think of it as encouraging hindsight while it is still foresight. Any suggestive communication strategy that orients clients experientially to future events is an age progression pattern.

The single most powerful predictor of therapeutic response across many different forms of intervention, from psychotherapy to response to antidepressant medications, is the quality of clients' expectations (Hunter, Leuchter, Morgan, & Cook, 2006; Kirsch, 1990a). Likewise, individuals' tendencies toward optimism or pessimism, a dispositional orientation toward the future, predict their quality of life, from mood and health to job performance and social likability (Seligman, 2011). Thus, paying attention to clients' view of the future makes good sense on many levels.

Projecting on the basis of current trends what is likely to develop in the future is not just a pastime for futurists. Foresight is a vital self-management skill and is clearly the best tool of prevention that therapists could be teaching their clients, if only more of them would have enough foresight to do so. People have the capacity to plan and allow for the possibilities of future experience but too often use it in a detrimental way by imagining worst case scenarios. Thinking ahead in such anxiety-provoking ways can build resistance to thinking about the future at all, so sensible planning falls by the wayside.

Foresight is a resource that can become more skilled and efficient with practice. But, even in basic form, most people have some sense of how today relates to tomorrow. Common remarks like, "See you there next week," "I'll read that report tomorrow and get back to you on it by next week," "I'd like to enroll in that new program next year," and "When I retire I'd like to spend my time traveling," are all statements of intent regarding future experience. To make such statements realistically, which is obviously the key consideration, people must project some portion of themselves into that experience and imagine in some degree of detail what it would or will be like. Such statements are unrealistic when they are global wishes rather than detailed plans, disregarding inconveniences that would make such plans unlikely to succeed.

There are differing theoretical views on the dynamics of future orientation. Some hold the view that clients' future projections are purely fantasy material that have little or no relationship to the actual life experiences that will unfold over time. Such projections are considered useful in the same way as Rorschach inkblot responses might be—as interesting reflectors of unconscious

dynamics only, with little true bearing on the future. Others hold the view that the unconscious has within it a "preprogrammed destiny" acquired early in life through socialization according to believers with a social-learning orientation, acquired genetically according to believers with a biological orientation, or through the evolving soul for those with a spiritual or philosophical orientation. People's destiny is thought to become available to them through hypnotic patterns of age progression, when the "all-knowing" unconscious is tapped by the clinician.

My own perspective is that age progression is simply an extrapolation of personal trends, including clients' motivations, feelings, behaviors, and interactional patterns. Clients in hypnosis can examine and extrapolate relevant trends and, depending on their degree of insight into them, can anticipate eventual outcomes. Many personal patterns, conscious or otherwise, are quite predictable. You don't have to be a psychic to predict someone's reactions or behaviors accurately when you know something about how they tend to see things. That applies to predicting yourself as well. But age progression is more than just predicting. It's about becoming absorbed in the future as if it's now, giving rise to understandings, perceptions, and emotions not easily accessible in other ways.

General Applications of Age Progression Age progression can be used in at least two general, complementary ways. One is as a therapeutic intervention, and the other is as a check on one's clinical work. Both applications involve guiding clients into a future orientation, but for different purposes.

Age progression for therapeutic purposes can be structured in many ways. Most clinicians are well aware of the "self-fulfilling prophecy," the unconscious alignment of behavior with an expectation. One way to think about age progression is as the deliberate creation of a therapeutic self-fulfilling prophecy, that is, an expectation of change that can be the foundation for clients developing new adaptive behaviors. Irving Kirsch's view of hypnosis as a *nondeceptive placebo* is a parallel construct highlighting the vital role of expectancy in hypnosis and psychotherapy (1994, 2000, 2006). Most important of all in age progression is the ability to experience some of the benefits of implementing the changes encouraged in clients through the therapy. To "jump ahead" and preview and even feel the positive consequences of making important changes helps motivate them to go ahead and actually do so. It takes the changes out of the realm of theory and gives them some life, some substance, in their mind. Many other therapies, such as cognitive therapy's use of a *success imagery* strategy in which clients mentally rehearse the desired behavior leading to successful results, also recognize the value of lifting them out of the moment and orienting them to future benefits, but hypnosis can make this process more intense and multidimensional (Torem, 1992, 2006; Yapko, 1992, 2010).

Utilizing age progression for the purpose of checking on one's work is a way of assessing two very important dimensions of therapeutic intervention: whether the intervention's results will likely be lasting ones; and what likely

impact on clients' lives the intervention will ultimately have. Even though the change under consideration may seem clearly beneficial, there may be less obvious forces in effect that may prevent clients from fully succeeding. Age progression allows them to project into the future and consider how they look and feel after the change, how they look and feel handling old situations in new ways, how others will likely react to their change, what areas might continue to be difficult, and in general, which areas of their life have been affected for better or worse. Such information can be invaluable to the clinician in formulating the intervention while simultaneously checking on the impact of his or her work.

If clients experience age progression and still have the presenting complaint well into the future, clearly the therapy isn't over. For example, if after working with a client who wants to stop smoking the clinician senses that the client has been guided into accepting that she no longer needs or wants to smoke, and then the clinician does an age progression technique and the client still experiences herself a month (a day, a week, a year, whatever) into the future as a smoker, then the therapy cannot have been successful. Questioning the age-progressed client about various dimensions of her "recent" experience posttherapy can help the clinician discover what factors might play a role in the client restarting or continuing to smoke that had not been adequately addressed in the intervention. If the age-progressed client claims she wasn't smoking after therapy until she got into an argument with her boss, the clinician now knows that some tools must be provided for effectively managing such a situation without relapsing into smoking. Thus, age progression can serve result-checking as well as strategy planning purposes.

Milton Erickson had a little sneakier, albeit sophisticated, use for age progression, which he called a *pseudo-orientation in time* (Erickson, 1954/1980). By having his patients go forward in time and relate to that time as the present, Erickson could ask them how they got over the problem—specifically what Erickson said or did for them—or what they learned or decided that helped them overcome their problem. When patients gave him the details of the "past" therapy that had helped them, Erickson facilitated amnesia for having done so and thereby obtained his therapeutic strategy directly from the patient themselves.

Posthypnotic suggestions necessarily involve age progression and sometimes amnesia as well. A suggestion is given for clients to respond in a particular way in some future context, and for clients to accept such a suggestion they must experience some degree of future orientation. In fact, orienting clients to positive future possibilities is a necessary part of any psychotherapy. Even therapeutic approaches emphasizing insights into the past can encourage some future orientation when such insights are expected to generate new possibilities in clients' future.

Approaches to Eliciting Age Progression Patterns for facilitating age progression can range from structured, direct approaches to less direct and

more conversational communications, such as presuppositions. The direct approaches for facilitating age progression closely parallel the direct approaches described for age regression. These might include a "special vehicle" to take you into the future, a movie screen on which to watch or even step into a movie of the future, a book in which to read about your future and how it happened, or the imagery of a photograph collection of future events to view are all structured approaches to facilitate a future orientation or projection. As you can tell, the approaches to hypnosis are as varied as your imagination allows.

A simple, direct, permissive suggestion approach to age progression is exemplified in the following paragraph:

> … And now that you've had the opportunity to discover something very important about yourself, I wonder how many ways you'll find to use this new ability of yours creatively in your own behalf … and it can be as if a long time has passed since this session … a few days … and time passes so quickly … then a few weeks … and a few months ago we spent some time together where you learned that you could feel so good … and you had a thought at that time … that allowed you to look at yourself differently then … and feel differently now … and as you look back over all the time that has passed since then, how has that thought affected you? … How are you different? … What can you do now … that you couldn't do back then?

In this example, clients are encouraged to integrate some new thought or learning into their life in a way that will prove beneficial. Suggesting directly to clients that it is "as if a long time has passed" orients them to the future as if it were now, a time to reflect on the recent change and its consequences. Questions such as those in the example require increasing involvement in the "then is now" experience and can provide concrete ideas to the clinician about additional factors to include in the overall intervention.

Indirect suggestions for future orientation may include the following:

1. Metaphorical approaches (e.g., "I'd like to tell you about a client I worked with who could clearly imagine herself 2 months after our session doing exactly what we're talking about now and when she saw herself that way she discovered …")
2. Embedded commands (e.g., "I sometimes like to look around and wonder what will happen in the future when you can look back at and feel good about all the changes you have made.")
3. Presuppositions (e.g., "I wonder exactly where you will be and what you'll be doing when you happily realize you haven't smoked in days.")
4. Indirect embedded questions (e.g., "You can tell me about how you will describe the way you solved this problem to your friends, can't you?")

Each of these approaches and examples demonstrates a capacity for guiding clients into a mental set for developing positive expectations for the future.

Table 19.3
A General Age Progression Strategy

1. Induction
2. Building a response set
3. Metaphors regarding the future
4. Identifying positive resources
5. Identifying specific future contexts
6. Embedding the positive resources identified in #4
7. Rehearsal of behavioral sequence
8. Generalization of positive resources to other selected contexts
9. Posthypnotic suggestion
10. Disengagement
11. Reorientation to waking state

Age progression patterns are the bridge to get from here to there, from now to later. If the imagination doesn't create new directions, the will doesn't have anyplace to go but around and around.

Table 19.3 contains a general age progression strategy that may be adapted to individual needs in the context of psychotherapy. This strategy illustrates the idea of sequencing steps in a hypnotic process in an effort to facilitate the greatest degree of responsiveness in the client. The goal of the strategy is to encourage positive expectancy.

The general strategy involves 11 steps, described succinctly as follows:

Step 1 involves providing an induction of any type.

Step 2 involves offering a set of verifiable suggestions that establish a momentum for responding positively to the clinician.

Step 3 involves offering at least two metaphors regarding the future, such as how changes will happen in science, in medicine, in society, and so forth, indirectly orienting clients to considering future possibilities.

Step 4 involves identifying valuable specific resources (e.g., intelligence, sensitivity, perseverance) that clients already have.

Step 5 involves identifying specific challenging future situations clients will be facing that are a basis for concern.

Step 6 involves associating clients' existing resources to the likely future contexts where they would be helpful.

Step 7 provides an opportunity for a "rehearsal" of the revised future sequence as if it were happening now.

Step 8 provides a chance to identify several other contexts where that same new application of a skill would also be helpful.

Step 9 involves specific suggestions to use the skill in contexts wherever it would be helpful.

Step 10 brings the future-oriented work to a close and reestablishes the ties to the current context.
Step 11 is guiding individuals out of hypnosis.

Hopelessness and helplessness are routinely found in clients in distress. Age progression as a means of building a realistic sense of hope and as a way of empowering clients to take charge of their life is a vital component of good therapy.

Hypnotic Amnesia

Description Hypnotic amnesia is a suggested inability to remember and can be most simply described as eliciting the experience of forgetting something. In both hypnosis research and clinical practice, hypnotic amnesia generally involves the inability to recall items specifically suggested either directly or indirectly to be unavailable for recall and subsequent recall when the amnesia suggestion is reversed (Cox & Bryant, 2008). The quality of the amnesia may be broad in scope, such as childhood memories before age 9, or may be specific to a certain type or category of information, such as what happened during the robbery. As Theodore X. Barber (2000) described in his discussion of *amnesia-prone* individuals, the quality of their amnesia and the proneness toward amnesia may be important both diagnostically and therapeutically (Barnier & Council, 2010).

Hypnotic amnesia has been the subject of considerable research in the domain of experimental hypnosis. Suggested and reversible amnesias hold the potential to reveal much about the cognitive basis for memory and other unconscious processes. Many different viewpoints have been developed over the years, including the views of hypnotic amnesia as a socially prescribed role enactment (Wagstaff, 2004), a disruption of explicit but not implicit memory (Mazzoni et al., 2010), and a prescribed breakdown of specific memory retrieval mechanisms (Kihlstrom, 1980, 1987), to mention just a few.

Whenever you try to remember something, you attempt to bring information from somewhere in your unconscious into conscious awareness. Until you read this sentence, you were very probably not thinking of your old neighborhood where you grew up. That memory, however, is in your unconscious until you choose to retrieve it. Not all memories are available to be brought into conscious awareness, though. Some experiences were too superficially attended to and were not incorporated into long-term memory, while others had no personal meaning and thus were not integrated into memory in any recoverable way (Johnson, 1991; Parkin, 1993). Still others were so personally threatening that they had to be defended against. The classic defense mechanism called "repression" operating in tandem with dissociation are the primary mechanisms of hypnotic or structured amnesia. Repression and dissociation refer to the mind's ability to "split off" threatening thoughts, experiences, feelings, and

impulses in the unconscious, allowing individuals the opportunity to avoid consciously having to acknowledge and deal with the threat (Spiegel, 2010). These processes are especially prominent in dealing with trauma (Peebles, 2008). Therapeutically, the goal of many forms of treatment involving such traumatic memories has been to uncover and "work through" them. Working with people's memories, as well as the lack thereof, must be approached delicately, and taking advanced training in this area is very highly recommended.

In everyday living, examples of forgetting that parallel hypnotic amnesia are abundant. Lost keys, forgotten phone numbers, missed appointments, forgotten names of people you know you know, missed assignments, showing up on the wrong day for a meeting or date, forgetting details of significant experiences, and forgetting where you hid something important are common examples. There are countless opportunities in daily life to observe people forgetting things that may, on the surface, seem unforgettable. Some conditions serve to enhance memory, and some serve to interfere with memory. Some of these are biological in nature, as Ernest Rossi described in his considerations of state-dependent learning (1996, 1998, 2001), and some are social and situational. Structuring someone's experience hypnotically to create the conditions in which information can be "split off" to deliberately create amnesia may occasionally be a goal in the course of treatment. Why might a clinician want to foster amnesia in a client?

General Applications of Amnesia Having insight into one's motivations and associated intrapsychic dynamics is thought to be the primary vehicle of change by a number of different schools of psychodynamic psychotherapy, primarily those in which the conscious mind's role is considered to be the most significant in the process of change (Nash, 2008a). Herein lies a fundamental difference between the utilization approach to hypnosis and other therapeutic approaches that emphasize developing greater conscious awareness. The utilization approach emphasizes the greater positive potentials of unconscious processes and thus makes regular use of amnesia (Haley, 1973; Zeig, 1980). The unconscious is considered to be an active and capable part of each person, able to integrate memories and learnings into patterns of living that allow the person to cope. Is the unconscious really capable of organizing responses and patterns of coping independent of conscious understanding? It is tempting to think of an unconscious that can be trusted to generate positive responses to life stressors, but clearly such a one-dimensional view of the unconscious isn't tenable, as discussed earlier. However, some responses formed at unconscious levels are, in fact, helpful to the individual. Thus, the use of amnesia to split off conscious awareness to focus on stimulating unconscious processes may have therapeutic utility.

When the unconscious is able to integrate new information that has special significance, perhaps because of its point of origin, namely, the suggestions of a trusted therapist, and its relevance, synergistically added to the preexisting

motivation to change, clients can undergo changes seemingly with little or no awareness for how the change took place. For example, are you conscious of specific reasons you no longer either like or wear that expensive piece of clothing you bought just a short while ago that you thought was so great at the time? Probably not. The change in your attitude "just happened."

Milton Erickson was a firm believer that the unconscious can be more powerful in generating changes than any other part of the person and that if the appropriate information is provided to clients' unconscious from within their frame of reference, ideally with minimal interference from the conscious mind, the unconscious could effect rapid and lasting change. Consequently, Erickson developed a variety of ways to facilitate amnesia to promote change at an unconscious level (Zeig, 1985a). By inducing clients to consciously forget the various suggestions and experiences provided, the clinician can enable their unconscious to form its own unique response, free to use the hypnotic suggestions and experience as creatively and idiosyncratically as it desires. More often than not, clients' solution catalyzed by the clinician's suggestions is more creative than the clinician's solution.

Beyond offering therapeutic suggestions to the unconscious mind for it to use its hidden resources for problem solving, amnesia can be and frequently is used more directly to deliberately help repress and dissociate hurtful memories if deemed appropriate to do so (Lankton, 2001; Voit & Delaney, 2004). Caution must be exercised in facilitating repression by assuring clients that the memory is not gone forever, only that it is going to be "stored in a safe place … where it need not interfere with your daily living … where it can be retrieved again any time you wish to do so." In the event that, for whatever reason, clients need to have access to that memory, it can be available since it has only been set aside, not eliminated. Remember, the mind is not a computer whose "memory cards" can be erased. Suggestions for amnesia in such cases are likely to be accepted only when some resolution has occurred first. Additional suggestions that dissociate the intense feelings from the memory can also be offered. (See the section on "Dissociation" later in this chapter.) Then, in the event clients do reexperience the memory, it can be without all the intense emotions previously associated with it.

Structured Versus Spontaneous Amnesia Amnesia is a common characteristic of deeper hypnotic experiences. When clients emerge from hypnosis, they may have little or no recollection for what the hypnotic experience involved, even if no direct suggestion for amnesia was offered. Such amnesia is referred to as *spontaneous amnesia* or *posthypnotic amnesia* for obvious reasons and is most evident in the amnesia-prone personality (Barber, 2000). If amnesia is a specific response the clinician wants clients to develop, gambling on spontaneous amnesia is not a certain bet; rather, playing a more active role in facilitating a structured amnesia increases the likelihood of obtaining their amnesia response.

Table 19.4
Techniques of Hypnotic Amnesia

Indirect suggestion	Confusion
Distraction	Metaphor
Structured/direct	Seeding

Amnesia is not automatic with hypnosis, as many erroneously believe. In fact, for those who rely greatly on intellectual means of self-control, paying careful attention and remembering everything that happens may reduce anxiety. Inducing amnesia in such persons, as might be expected, is more difficult. If clients are motivated to remember suggestions and experiences during hypnosis, they will. When spontaneous amnesia occurs, it is, in part, a reflection of clients' trust in the clinician's skills. It indicates that they didn't feel the need to scrutinize everything the clinician did.

Deciding what things clients should and shouldn't be aware of is one more area of responsibility on the part of the clinician when attempting to structure amnesia. Ultimately, of course, clients are free to accept or reject whatever suggestions they choose, but the clinician can influence them in undesirable ways, as you may recall from the earlier discussion of human suggestibility. Amnesia can be a very tricky process, and its power, like that of the unconscious, is easy to underestimate.

Strategies to Elicit Amnesia Amnesia, more than any of the other hypnotic phenomena, is less likely to be obtained the more directly the clinician suggests it. Directly suggesting to individuals that they "forget everything that took place during this time" can be very threatening, even to highly responsive clients. In facilitating amnesia in clients, the indirect approaches are generally more palatable to people, in my experience. Table 19.4 lists techniques of hypnotic amnesia.

If a direct approach to amnesia is employed, it is probably more likely to be accepted if offered in a more permissive manner, such as, "You can comfortably choose to forget about that experience now, simply because it no longer has a place in your life."

Indirect approaches may take a variety of forms, including *indirect suggestions*, *attentional shifts*, and *confusional suggestions*. Indirect suggestions for amnesia create the possibility of amnesia occurring without your overtly asking for it as a specific response. The following is an example of an indirect and distracting approach to amnesia:

> … And as you continue to relax, each breath soothing you … I wonder how much attention you have paid to the different thoughts floating through your mind … Your mind can be so active while it relaxes … and then you can realize how difficult it is to remember what I was talking about exactly 7 minutes ago … and you could try to remember what I was

> saying 9 minutes ago, or what you were thinking about 4 minutes ago, but doesn't it seem like much too much work to try and remember? … It takes more effort than it's worth … so why not let yourself relax comfortably … knowing you don't have to remember when it's too much work to even try?

This example is indirect because it doesn't specifically suggest to clients that they forget; it only describes the difficulties of remembering. Another indirect suggestion for amnesia is, "You can remember from this experience only what you choose to remember." This suggestion carries the unspoken implication that "you can forget what you choose to forget." I view this suggestion as a respectful way of offering amnesia as a choice for clients to make without demanding it.

Another indirect approach to facilitating amnesia is the attentional shift. The mechanism for this approach is easy to understand when you consider a routine interaction. You say to your friend, "I have something I have to tell you." Your friend says, "Well, I have something to tell you, too, and it's really important so let me tell you first." You agree, so you listen and then respond to your friend's concern. Finally, when she is through talking and says, "OK, now what were you going to tell me?" and then you say, "Uh, well, gee, I uh … forgot," the irritating but predictable response from the other person then is, "Well, it must not have been very important!" What actually took place? Your attention was on a particular "track," a particular line of thought. But when you left that track to attend to your friend's input, the flow of thought was interrupted and was difficult to retrieve, thus creating a temporary amnesia. You have the information "on the tip of your tongue," but the harder you try to remember it the more elusive it is. Only when you divert your attention away from deliberate effort to recall it does it eventually float back into awareness.

Shifts in attention obviously have an impact on how information goes back and forth between the conscious and unconscious. Deliberately shifting clients' attention away from their hypnotic experience is one way to get them to "jump tracks" and thereby develop amnesia for the hypnosis. To do this, when clients are disengaging from hypnosis, the clinician can gracefully and congruently distract them by asking about something totally irrelevant to the content of the hypnosis session. For example, the clinician can look bothered and say something like, "Oh, I just remembered. I needed to ask you which tests you had done at your last physical examination. Do you recall?" By encouraging clients to abruptly shift into thinking about their last physical examination (or whatever), you give them no opportunity to consciously analyze the hypnotic experience they just had, letting it slide to the "back of the mind" while their awareness shifts to your question and how to answer it. When they slip out of awareness, your suggestions may still be processed unconsciously in a goal-oriented fashion, as discussed in Chapter 5. You won't know, however, whether their unconscious has integrated anything until subsequent meetings

when you have the opportunity to find out if anything has changed and what degree of conscious awareness they have for how things changed.

Discouraging conscious analysis by jumping tracks or otherwise encouraging amnesia to develop inhibits opportunities for clients to pick apart or reject dimensions of the hypnotic experience that conscious analysis might deem irrational. Hypnosis sessions often involve suggesting experiences, such as "floating peacefully through space and time," that may be emotionally powerful but are logically impossible. The unconscious can respond meaningfully to things that make very little sense to the conscious mind, termed *trance logic*, a point that leads me to the next approach for facilitating amnesia.

Confusion as an induction technique was discussed earlier. Confusional suggestions may also be used to facilitate the various hypnotic phenomena and can be especially useful in obtaining amnesia. In responding to confusional suggestions, clients become increasingly focused on trying to make sense of them. As in the previous approach, their attention shifts—jumps tracks—from where it was to the current confusing inputs, but the added element of their motivation to form a meaningful response can make for an even more powerful approach to eliciting amnesia. The following is an example of a confusion technique for the purpose of facilitating amnesia:

> … And now that you've had the opportunity in this session to discover new possibilities … while you can learn from past experiences … your conscious mind can begin to wonder … How it will know which things to remember … and which things only your unconscious need know … and then you can remember … to forget … or you may choose to forget to remember … but when you remember to forget what you've forgotten to remember … your memory of forgetting forgets what it has forgotten … but you can only forget what you've forgotten when you realize it's too difficult to remember anyway … and then you can forget all the confusion and relax even more deeply.…

As more of their attention is engaged to sort out the confusion, clients' unconscious can respond to the embedded suggestions for forgetting. Whereas the attentional shift is typically used at the close of the hypnosis session, although not necessarily so, the confusion approach can be easily integrated at any point in the hypnotic process.

Other approaches to facilitating amnesia include the following:

1. Metaphors, in which stories are told with embedded suggestions for forgetting ("… and when she opened her eyes it was as if from a deep sleep, barely able to remember anything but the good feelings of a restful night.")
2. Seeding, in which advance hints are provided of the amnesia suggestions to come later ("Some people experience such deep or meaningful

hypnosis that when they reorient later it's surprising how little there is to remember … and it's so interesting how they change for the better even though they don't necessarily remember how.")

3. Dissociation, in which suggestions can be offered about remembering and forgetting as separate mechanisms that can function independently ("Your ability to remember is complemented by your ability to forget … and when your thoughts remember that situation, your feelings can forget to be there because they are remembering someplace else to be of greater importance and comfort.")

Observation of yourself and others in various situations where memory is on display can teach you a lot about the routine nature of remembering and forgetting. Further study of the nature of human memory is also recommended to guide one's developing skills in the use of amnesia. For particularly good considerations, see Daniel Schacter's (1996) book *Searching for Memory: The Brain, The Mind, and The Past* and Nobel prize winner Eric Kandel's (2007) book *In Search of Memory: The Emergence of a New Science of Mind*.

I had more things to say about amnesia, but I've forgotten what they were.

Analgesia and Anesthesia

Description The potential to reduce pain to a manageable level or even eliminate it altogether is one of the most meaningful applications of clinical hypnosis. Given the large number of people suffering with chronic and debilitating pain and the potential for any of us to suffer pain from injuries and medical conditions, the value of any tool for managing pain effectively is obvious. Consequently, pain relief through hypnosis may well be the most intensively studied of all the hypnotic phenomena and may also be the most empirically well-supported application of hypnosis.

Since pain management is so vital a concern to so many, an entire chapter in this volume (Chapter 25) addresses the topic of clinical hypnosis in the management of pain in great detail, including descriptions of issues, applications, and techniques.

Catalepsy

Description Catalepsy is defined as the inhibition of voluntary movement and is associated with intense experiential absorption. It is the outer manifestation, the behavioral result of focusing intently on a new and different reality, whatever it may be. Cataleptic responses may include a fixed gaze, general immobility, the "waxy flexibility" commonly associated with catatonic patients who maintain their limbs in whatever position the clinician places them, muscular rigidity, slowed movements (called psychomotor retardation), and the slowing of basic physical processes such as breathing, blinking, and

swallowing (Weitzenhoffer, 2000). Signs of catalepsy can be used as indirect indicators of clients being in hypnosis, or they may be directly suggested for specific therapeutic reasons to be described shortly. Catalepsy is regarded as one of the most basic features of hypnotic experience, for it is associated directly or indirectly with virtually every other hypnotic phenomenon. Catalepsy helps pave the way to let go of the "old" reality long enough to create a therapeutic experience of age regression, analgesia, sensory distortions, or whatever.

As Ernest Rossi pointed out in his discussion of catalepsy (Erickson & Rossi, 1981), the so-called everyday trance, that is, the spontaneous hypnosis that can arise in the course of daily living, is often a period of time featuring catalepsy; individuals may be daydreaming, self-absorbed, enthralled, captivated, but always preoccupied to the point of temporary immobilization by the intensity of the focus. Routinely over dinner, for example, people stop mid-reach for the pepper (or whatever) when the conversation turns intense and absorbing for the moment. Similarly, people will stand rigidly fixed in one spot, in one position, when more and more of their mind is called on to make sense out of a situation that seems to require a meaningful response.

Stage hypnotists typically demonstrate a *full-body catalepsy* by suggesting that volunteers develop extreme stiffness of the entire body (e.g., "It is as if your body is a long, thick piece of steel") and then suspending their rigid body between two chairs. Some add a little more dramatic flair to the demonstration by standing on them while they are suspended in that way. Suggestions to clients for a part of the body to be stiff and rigid, such as an arm (e.g., "Your arm is so stiff and rigid that you will find yourself unable to bend it"), is a demonstration of *arm catalepsy* or *large-muscle catalepsy* if those suggestions are accepted. Suggestions to clients that "the eyelids or eye muscles of your closed eyes are so rigid or relaxed as to prevent your eyes from opening" may be accepted by them, resulting in *eye catalepsy* or *small-muscle catalepsy*.

Suggestions of catalepsy are frequently used to assess clients' responsiveness to suggestion, as you may recall from the discussion of suggestibility tests. Responses to arm levitation procedures and the special "Handshake Technique" that Milton Erickson developed (Gilligan, 1987) as well as to various other pattern-interruption approaches are demonstrations of catalepsy. Arm levitation as a suggested response shows a catalepsy of the floating arm suspended in mid-air. The Handshake Technique involves initiating a routine handshake with someone and then interrupting the usual sequence of making hand contact by doing something else at the moment (e.g., bending over to tie one's shoes) just before hands would have touched. The other person's hand is left suspended in air, and the other person is now more externally oriented and responsive as he "freezes" and tries to make sense out of such an unusual situation.

For a long time, catalepsy was considered to merely be a passive response on the part of clients, but so was hypnosis in general (Watkins, 1987). For

someone to focus so intently on the suggestions of the clinician, the demonstration of catalepsy must be viewed in the same way as hypnotic responses in general—as an active and dynamic process requiring the proactive formulation of meaningful responses. Catalepsy implies an intense internal absorption on one or more levels that also indicates a high degree of activity and receptiveness to the guidance of the clinician on other levels. This is why clients focused on one level may have their arm placed in a position and leave it there, literally too preoccupied with other more immediate things to think about than expending effort to move it (Barber, 1996b).

General Applications of Catalepsy There are numerous therapeutic purposes for eliciting catalepsy, but they can be described in two general ways. Catalepsy either can serve to facilitate deepening through clients' recognition of their nonvoluntary responses or can be a target response in itself. As a deepener, catalepsy can be a basis for securing and maintaining attention "as you discover yourself getting more mentally focused and your body becomes too heavy to move." Catalepsy as a target response may be used, for example, to assist any clients whose physical movements need to be minimized to recover more quickly and comfortably, such as in back injuries or burns.

Strategies to Elicit Catalepsy Anything that captures clients' intense interest can facilitate cataleptic responses, including interesting stories, surprises or shocks, and confusion. Thus, catalepsy can and typically does arise as a spontaneous hypnotic phenomenon even if you don't suggest it. Eliciting catalepsy as a response from clients can be accomplished directly or indirectly, verbally and nonverbally, as desired. Direct suggestions for arm catalepsy are evident in the following suggestions for arm levitation:

> … As you continue to breathe in … and out … at a rate that's comfortable for you … you can start to notice which of your arms is beginning to feel lighter than the other … light, almost weightless … and your hand can begin to float easily and effortlessly … rising … that's right … lifting without any effort on your part … your hand and arm can float in the air as if attached to a very large helium balloon, … and you can be surprised to discover how pleasurable it is to experience your arm floating straight out before you … as if it were completely weightless, … and it can stay there effortlessly while you begin to notice another sensation that can be of even greater interest to you.…

An indirect way to encourage catalepsy is to offer general suggestions for relaxation and immobility, such as in the following:

> … It can feel so good to you to know your body knows how to take care of itself … It knows how to breathe comfortably … in, and slowly out … effortlessly … and it knows how to relax deeply … and you will keep on breathing effortlessly … as your mind drifts off to some special

> memory … a memory you haven't thought about in a long, long time … and it also knows how to sit quietly still while you get absorbed in enjoying that memory … and isn't it comforting … and soothing … to know your arms can rest heavily on the chair with no need to move them? … and it takes more effort than it's worth to move when you are so comfortable.…

Both of these examples are obviously examples of verbal approaches for eliciting catalepsy. The use of gestures and touch can facilitate catalepsy on a nonverbal level. You can model catalepsy as you begin your induction, showing a fixed gaze and a gradual reduction in movement as you proceed. Using your body as a model, you can deliberately shift from the animated patterns of routine conversation to a demonstration to your clients of the potential immobility of hypnosis. By gradually focusing yourself intently on your clients, suspending bodily movement, and verbalizing your suggestions in an increasingly slow, absorbed, "hypnotic" way (employing the communication patterns described throughout), you are modeling to them the possibility for catalepsy. If the rapport is adequate, they can follow your leads. You can even go a step further in modeling by gesturing slowly and deliberately stopping mid-gesture at well-chosen times as if deeply preoccupied, thereby demonstrating the possibility of being so absorbed in thought as to lose track of voluntary motions.

Many advanced techniques build on the unconscious responses associated with catalepsy, particularly those that emphasize mind–body healing (Rossi & Cheek, 1988). While general immobility is the typical application or sign of catalepsy, remember that catalepsy has been defined as the inhibition of voluntary movement, which leaves ample room for involuntary or unconscious movement.

Dissociation

Description Previously we have explored dissociation in the context of mental functioning during hypnosis when considering Ernest Hilgard's (1992) neodissociation theory of hypnosis, which postulated a "splitting off of certain mental processes from the main body of consciousness with various degrees of autonomy" (p. 69). In terms of clinical utility, dissociation can be defined as the ability to break a global experience into its component parts, setting the stage to amplify awareness for one part while diminishing awareness for the others.

Most clinicians learn about dissociation in the course of their clinical training but almost invariably in the context of psychopathology while studying the dissociative disorders, such as dissociative identity disorder (DID), psychogenic amnesia, and fugue states. Dissociation is considered to be a basic response of people in trauma, such as when a rape victim reports she was floating above her body during the attack (Spiegel, 2010). Dissociation is thought to be so extreme in some instances that individuals can dissociate and develop amnesia for intense and prolonged trauma. Dissociation defensively applied in such

a way has been linked to the onset of the dissociative disorders (Barber, 2000; Colletti, Lynn, & Laurence, 2010; Spiegel, 2010).

Dissociation, like each of the other hypnotic phenomena, is neutral in value, capable of being applied for positive or negative purposes. Dissociation to repress trauma that deteriorates into a dissociative identity disorder is clearly an unhealthy adaptation. In contrast, dissociation as a pain management strategy allows one to "step away from the pain," a potentially helpful application of the same principles of detachment. It's important to appreciate that what defines the positive or negative value of some process is the outcome it generates, not the process itself.

Dissociation is a natural experience, for all persons are capable of processing and responding to information in detached ways they are not even aware of. On a daily basis, people talk to disembodied voices through an instrument called the telephone. Physical processes of blinking, swallowing, adjusting the body, and breathing go on without any conscious involvement whatsoever. All individuals have had the experience of feeling divided within themselves, as if simultaneously both participant and observer in some experience. Even common clichés reflect dissociated states: "I'm beside myself with joy," "Part of me wants to go, but another part of me doesn't," "I'm out of my head to do this."

Through dissociation, people do not necessarily have to be attached to their immediate experience, involved, and "present" if it serves them better not to be. They can "go through the motions" but not really be "there." Awareness can drift off somewhere, preoccupied with whatever else has its attention, thereby allowing for more automatic, unconscious responses. The deeper the hypnotic experience, the greater the degree of dissociation and the greater the opportunity for nonconscious responses. Hypnosis is by its very nature a dissociative experience and dissociation may be regarded as the defining characteristic of hypnosis: you can be in hypnosis without being relaxed, but you can't be in hypnosis without some degree of dissociation being evident.

General Applications of Dissociation Dissociation may be used therapeutically in a wide variety of ways. Splitting an integrated experience into parts can make for some very interesting possibilities. For example, one might split the intellectual component of an experience from the emotional component. This would be quite helpful to clients who are confused in trying to distinguish their beliefs from their feelings.

I Have the Feelings but Not the Memories This particular thought/feeling dissociative phenomenon is particularly instructive about mental functioning in one particular way, and to illustrate the point consider how this phenomenon is demonstrated in stage hypnosis shows. The stage hypnotist suggests to subjects that they imagine (positively hallucinate) watching the funniest movie they have ever seen. They comply, of course, and begin to laugh uproariously. Next the stage hypnotist has them positively hallucinate seeing the saddest

movie they have ever seen, and now they begin to blubber and cry, often with real tears. Then the stage hypnotist suggests the movie is getting funny again, and they are right back to laughing uproariously again. This is an impressive display of the "induction of affect," the ability to induce emotional states in people through suggestion. What's more interesting, though, is when the stage hypnotist then asks subjects, "What is so funny or sad about your movie?" The typical subject responds by saying, "I don't know!" Now, pause for a moment and ask yourself, what is going on here?

The subjects aren't merely reluctant to describe what events transpired in the movie to generate such apparently intense emotions and reactions of laughing and crying. Rather, they simply don't know, as they truthfully stated. The stage hypnotist has suggested experiencing the emotions of funny and sad, but the feelings are not associated with a particular memory; they are feelings dissociated from a specific context.

The fact that a dissociated feeling can exist and influence behavior without being attached to a specific situation, only a general suggestion to feel the feeling, is something too many therapists involved in the repressed memory controversy didn't understand. If clients reported, "I have the feeling I might have been abused, but I have no such memories," therapists erroneously assumed that wherever there's a feeling, there has to be a situation associated with it to account for it. Then they went looking for situations that would justify the feelings, often unwittingly creating those situations in the process through the process of confabulation—filling in gaps in memory with imagined experiences that are virtually indistinguishable from authentic memories. Hopefully, you now have much better insight into the relationship among memory, trauma, and suggestibility through your study of hypnosis and can avoid such costly mistakes.

Dissociation and Parts of People Dissociation allows for the automatic, or spontaneous, responses of the client to occur: the forgotten memory can be remembered, the hand can lift nonvolitionally, the body can forget to move or notice sensation. Parts of the person that aren't normally given attention or a means of expression can be highlighted and utilized in new, expansive ways. Facilitating the expression of individuals' specific parts can have profound therapeutic impact. Finding and treating the "part" of clients that has felt weak and powerless, for example, when other parts of them feel strong and able enough to take meaningful risks can give the clinician an opportunity to help them resolve a troublesome problem that has existed "for no apparent reason." As another example, addressing the unconscious part of people who are feeling weak, powerless, and angry in the context of an intimate relationship can allow them to fortify that part in a way that is adaptive. Giving that part the opportunity to express itself more directly can help rid them of that part's previous symptomatic mode of expression. Hypnosis in conjunction with ego state therapy has been an especially well-developed model for working in

this way (Barabasz & Watkins, 2005; Eisen, 2010; Hartman, 2001; Phillips & Frederick, 1995).

Countless other examples of dissociation can be found in the literature on hypnosis, but the best examples are those found in the course of daily living. What situations do you observe people responding to in automatic ways? When are people least integrated in terms of mind and body? Intellect and emotion? Past and present? Optimism and pessimism? Masculine and feminine? The more polarities or "parts" you can generate on a variety of levels (i.e., physical, mental, emotional, behavioral, and spiritual) to describe the range of experiences people are capable of, the more you can appreciate how many different interrelated parts there are of human beings; each is capable of being dissociated and amplified for clinical use.

Too often, people have personal resources they could be using to help themselves, but either these resources are hidden from them behind walls of failure, bad assumptions, and feelings of hopelessness and helplessness, or they simply don't know how to access them. In that sense, the parts of them that may have appropriate skills for problem resolution are already present but dissociated. The clinician's role in such instances is to build new associations (i.e., cues, triggers, bridges) that will give clients access to more of their abilities in the desired context. Dissociation is thus a valuable stepping-stone in the process of becoming empowered to live well.

Strategies to Elicit Dissociation Suggestions that facilitate divisions of experience are suggestions for dissociation. For example, an induction can generate a conscious–unconscious dissociation (Lankton, 2010) simply by emphasizing clients' ability to experience things and learn things effortlessly and automatically (e.g., "Your conscious mind is listening to me while your unconscious is doing something even more important at a deeper level than you might realize"). The conscious mind is given ideas and experiences to focus upon while the unconscious is encouraged to respond in other ways and learn at levels beyond awareness. In addition to eliciting dissociation during hypnotic induction, dissociation can be facilitated through a variety of approaches, including direct suggestions for dividing experience into parts, Erickson's "middle of nowhere" technique, and indirect suggestions for subjective divisions.

Direct suggestions for division let clients discover or rediscover, as the case may be, that it is possible to have concurrent experiences on different levels and that these experiences can occur spontaneously, automatically, and with no planning. Suggestions for hand levitation exemplify such a dissociation, as do the other nonvolitional cataleptic movements. Suggesting analgesia by "feeling your body resting comfortably here while you see that small part of your body that was uncomfortable way over there" is another direct suggestion for division. (You'll notice many such suggestions in *The Case of Vicki* accompanying this text.) Suggesting age regression by saying, "Your feelings can go back to age 6 while the rest of you remains an adult with me in the

here-and-now," is yet another example of direct suggestion of dissociation. Anything you say that fits the pattern of the general dissociative suggestion that "part of you is experiencing this while another part of you is experiencing that" is a direct suggestion for dissociation. Further examples are evident in a variety of models of psychotherapy that make abundant use of dissociation without ever really identifying it as such, including gestalt (which emphasizes the integration of parts) and transactional analysis (which dissociates each person into parent–adult–child states).

A technique of dissociation that Milton Erickson often used is called the *middle of nowhere* (Zeig, 1980b). Since individuals are guided to someplace called *nowhere*, the paradox has the effect of dividing them between the experience of being someplace but also being no place. An example of this approach might sound like this:

> … And when you sit that way it can become so easy to recognize that *a part of you is here* … but when *the rest of you drifts away* … and it *can* drift away … and you really don't know where it goes, do you? … to the middle of nowhere … where there is no time … and there is no place … in the middle of nowhere … there can just be my voice … and your thoughts … and nowhere is such a fine place to be … because nowhere else can one be so free to be nowhere … after all, you always have to be somewhere, sometime … but not now … nowhere is fine … and the middle of nowhere is a very pleasant place to be, isn't it? …

In this example, clients are encouraged to let themselves go to nowhere in particular, with no need to have any ties to anyone, anyplace, or anything. As clients experience themselves splitting their awareness between here and there, the dissociation intensifies.

Dissociation is indirectly suggested whenever suggestions for a particular hypnotic phenomenon are offered. Metaphors, confusion, and other forms of indirect suggestion may all facilitate dissociation. Metaphors are essentially stories that encourage you to leave here-and-now and go experientially into the context of the story. Confusion as a facilitator for dissociation is an indirect technique in which one consciously and effortfully attempts to make sense of communication that seems nonsensical. Confusion preoccupies conscious attention struggling for clarity to the point of leaving the unconscious more open for suggestion.

Indirect suggestions for dissociation are contained in the following metaphorical example:

> … And I thought it might interest you to learn that I had a similar experience to the one you described … an experience that taught me a lot about myself and others … that I'd like to tell you about … and isn't it amazing how you can learn important things from other people's

> experiences that … on the surface … seem so routine? … Sometimes you can listen so intently … it's as if a part of you is experiencing it, and another part of you is watching yourself from a comfortable distance go through the experience … wondering what will happen … and how you'll feel when it's over … and then the things that were so confusing at one level are made clear by the parts of us that understand … at a much deeper level … how to think creatively … and there's a creative part in everyone, I'm sure you'd agree … and in the experience I had, I found myself in a situation.…

In this example, dissociation is suggested on a number of different occasions. A part is created that "experiences," another part that "observes," another that will "wonder," another that can "feel," another that can "clarify," and still another that can be "creative." Each of these parts can now be isolated, addressed, and utilized to accomplish some therapeutic goal. Each of these parts can be identified by clients as present in themselves, even though the suggestions are offered indirectly as comments by the clinician about himself or herself or as comments about people in general.

In facilitating dissociation, the final consideration for the clinician is related to the process of reintegration. Should the dissociated parts be reintegrated fully? Partially? Or not at all? Certainly an area of pain is best left dissociated, at least in part. Positive parts, such as the creative or adaptive parts, would probably need to be fully reintegrated. The task here for the clinician is to have some insight into client's needs and motivations to know what beneficial or harmful consequences might be associated with dissociating or reintegrating parts of them. You may recall that age progression as an approach can be useful to help in this process (Torem, 2006).

Developing insight into the multifaceted nature of dissociation can have an enormous impact on the future of your clinical interventions, for in every psychological disorder known to me an element of dissociation is present. Clinical artistry often involves redirecting dissociative processes in more adaptive directions.

Hallucinations and Sensory Alterations

Description Residents of state psychiatric hospitals, given the chance, can explain to you the cultural biases against hallucinating. Generally, people find it a bit unnerving in daily life to encounter someone who is experiencing things that no one else is. Comedian Lily Tomlin asked the question, "Why is it that when I talk to God I'm praying, but when God talks to me I'm schizophrenic?" Hallucinations that are involuntary or serve as a coping mechanism (albeit a highly dysfunctional one) are considered either neurological aberrations or projections from the psychotic patient's unconscious, depending on one's point of view. In any case, they are maladaptive and nonvolitional.

Hallucinations created hypnotically are suggested experiences that clients can have that are also removed from current, more objective realities but that are structured to be adaptive. They are suggested for a therapeutic reason, emphasizing the power of imaginative involvement and creativity in effective problem solving. Hypnotic hallucinations allow one to step outside conventional reality under appropriate conditions to have some beneficial experience that could not otherwise occur. For example, one therapeutic application might be to have clients go back in time (age regression) and have a meaningful conversation with a parent now deceased to settle some lingering personal issues.

A hallucination is, by definition, a sensory experience that does not arise from external stimulation. Simplistically, there are at least five senses in the normal human being; hallucinations may therefore exist in any or all of the sensory systems. For the sake of simplicity, the kinesthetic sense in this discussion will include separate but related sensory systems capable of detecting pressure, temperature, and muscle feedback that orient individuals to their body and position in space and to changes in motion. It is possible to hypnotically facilitate visual, auditory, kinesthetic (tactile), gustatory, and olfactory hallucinations (Edgette & Edgette, 1995; Kahn, 2010). Hallucinations can be further characterized as being either *positive* or *negative*. These terms do not refer to the emotional impact of the hallucinations on the individuals experiencing them but rather to the structure of the hallucinations.

A positive hallucination is defined as having the (visual, auditory, kinesthetic, olfactory, gustatory) experience of something that is not objectively present. For example, you can take in a slow, relaxing breath, and as you inhale you can smell the fragrance of baby powder … and as you smell the fragrance of baby powder, you can realize that you have just had a positive olfactory hallucination. (Feel a little more youthful now?)

A negative hallucination is not experiencing something sensorily that is objectively present—thus the flip side of the positive hallucination. As you read this sentence, your awareness can drift to a sound in your environment that you didn't notice until just now … and as you become aware of that sound, and the feeling of surprise that you didn't notice it earlier, you can realize that you have had a negative auditory hallucination.

In facilitating hallucinations, the clinician is altering awareness for sensory input. Many hallucinations associated with hypnosis arise spontaneously; others are suggested either directly or indirectly. For example, hypnotic analgesia can be thought of as a diminished sensory awareness for the kinesthetic level of experience. It may arise spontaneously simply because of the catalepsy associated with hypnosis. Another way to describe the same analgesic phenomenon is to say that, as you become increasingly absorbed on other sensory levels, perhaps experiencing vivid visual imagery, you dissociate and negatively hallucinate kinesthetic experience. As a second example, hypnotic amnesia can be described as the conscious forgetting of experience, but another way of

describing the same phenomenon is to say that clients negatively hallucinate the components of the experience. Specifically, clients might not remember what was said to them during hypnosis because they were so subjectively involved on another level that they negatively hallucinated the voice and suggestions of the clinician.

Positive and negative hallucinations occur routinely in the course of everyday living. Everyday examples of positive hallucinations include having a taste for food you crave, feeling itchy all over when you find an insect on or near your body, thinking you see someone you're trying to avoid wherever you turn, hearing someone call your name when no one is around, and thinking you smell something burning when nothing is. Everyday examples of negative hallucinations include not hearing the doorbell ring because you're engrossed in something, not noticing something on your way to work and then seeing it one day and exclaiming, "Wow! Where did that come from?" and not noticing that the milk you're drinking has gone sour until someone else tastes it and says, "Yecch!"

Sensory alterations and hallucinations are distinct but closely related terms. Sensory alterations are defined as changes in sensory awareness, either magnified or diminished in some way. The overlap between them exists because to facilitate hallucinations, the clinician must alter clients' sensory awareness, and in altering their sensory awareness sensory hallucinations will be created. Clients will have one or more of their senses made more or less sensitive and more or less active, depending on the desired outcome.

General Applications of Hallucinations and Sensory Alterations

Hallucinations may be used therapeutically to immerse clients in a situation that can't be reproduced in the "real" world. Guiding them into a situation where they can experience themselves, or the world, differently in some meaningful way obviously increases the range of their experience and can thus instill valuable new resources. When people get absorbed and hallucinate the details of the experience vividly, the suggested reality can become almost as real and powerful as real life. Clients can then have the experience of hearing words they longed to hear, experiencing feelings they missed feeling, seeing places and people they needed to see, and so on. Suggestions for sensory alteration can be used to associate good feelings to a situation or experience, as in the use of sensate focusing exercises that encourage greater comfort and pleasure in being touched nonsexually as a prelude to being sexually more comfortable. Likewise, suggestions for negative hallucinations can reduce reactivity to triggers for discomfort, as in no longer noticing something about someone that used to be irritating (Kahn, 2010). Through suggested hallucinations and sensory alterations, clients can have structured experiences that can facilitate their personal growth and development. The "believed-in imagination" of hypnosis is especially potent in this application (Sarbin, 1997).

Strategies to Elicit Hallucinations and Sensory Alterations Hallucinations can and often do arise spontaneously during the course of hypnosis sessions. Negatively hallucinating one's body (e.g., when people report, "I felt disembodied") or the voice of the clinician (e.g., "I didn't hear you after a while") are common experiences for the client in hypnosis. Also common are experiences of seeing and hearing faces and voices from the past during hypnosis, perhaps even smelling the remembered person's fragrance.

To deliberately facilitate the experience of hallucinations, both direct and indirect approaches can work well. Stage hypnotists demonstrate a direct approach to positive visual hallucinations when they suggest to their subjects that they can laugh uproariously when they "see the audience nude." A direct suggestion to experience something (e.g., "You can open your eyes and see yourself over there having that special experience") is usually sufficient; generally by the time a clinician attempts facilitating hallucinations, he or she has already attained sufficient rapport with and responsiveness in their clients.

Suggestions for hallucinations, whether positive or negative, should generally be offered in a positive suggestion structure so clients know what they are striving to experience. As an example, you can refer to the earlier part of this section in which I offered you a direct suggestion for the positive olfactory hallucination of smelling baby powder. I let you know in a very direct and specific way what kind of experience you could have. In working hypnotically with clients, the more details the clinician provides, the more sensory experiences they can have. Thus, extending an earlier example, if you want clients to see their deceased mother in the chair opposite them to finally have the meaningful conversation that never took place, the positive hallucination of Mom will be enhanced by having clients see their mother's clothing, smell her perfume, touch her shoulder, see her physical position, and hear her voice, all in as much realistic detail as possible. All of these suggestions can be directly offered, immersing clients in the experience more and more intensely with each suggestion. In general, positive hallucinations are fairly easily accomplished through direct suggestions, of which the following are some examples:

> … You can look over there and see someone you've wanted to see whom you haven't seen in a long, long time … and how does she look? …
> … You can hear a voice telling you something you really shouldn't not know … and whose voice is it? … And what does it say? …
> … You can smell the aroma of the coffee perking … and that smell brings you back to a situation you haven't remembered in a long, long time … and where are you?

In these examples, while the sensory modality in which the positive hallucination is to occur is specified (i.e., see, hear, smell), the content of the hallucination is not. The person, the voice, and the situation that clients should experience in these suggestions are left to their projections. You can now recognize these as process suggestions for hallucinations. If the clinician wanted to, it would be just

as easy to suggest that clients see a specified person, hear a specific voice, or experience a particular situation, providing all the appropriate sensory details.

Indirect suggestions may also be used to facilitate hallucinations. Suggesting that clients be aware of their arm is an indirect suggestion to not notice their leg. Referring to the earlier discussion on negative suggestions, it should be apparent why the negative suggestion, "Don't notice the pain in your neck," as a suggestion for a negative kinesthetic hallucination won't likely work. Thus, indirect suggestions for hallucinations usually take the form of positive suggestions for experiences that would preclude the unwanted experience. For example, rather than directly suggest, "You won't know anyone else is present," for clients to negatively hallucinate other people in the vicinity, such a negative hallucination is indirectly accomplished by directly suggesting, "You can be alone" or by the indirect suggestion embedded in the question, "Where did everyone else go?"

The following suggestions exemplify indirect suggestions for hallucinations:

… And how does it feel to see yourself standing over there as a child?
… And whose voice is that that you're hearing?
… And why didn't you notice earlier that your hands were floating effortlessly?
… And I went to the woods to hear the silence and smell the fragrance of pine needles, and I'm sure you know those sensations, too …

In these examples, suggestions in the form of presuppositions are used to facilitate clients seeing themselves, hearing a voice, and feeling floating hands. By asking them how it feels to see the child, whose voice it is they hear, or when they noticed their hands floating, the clinician presupposes that clients are having these experiences, an indirect suggestion to do so. The last example is a metaphor with embedded commands to indirectly suggest certain sensory experiences. "Hearing the silence" is also an indirect suggestion to negatively hallucinate ongoing auditory stimuli.

Since clients tend to suspend reality testing during hypnosis, they can more readily get absorbed in suggested realities. As you've learned, they generally retain some sense of objective reality (recall Hilgard's hidden observer), but only if they are aware of a more objective reality. Sometimes clients will get absorbed in hallucinations and not know they are hallucinating, as in the confabulations that lead people to believe they were abducted by hostile extraterrestrials. Thus, a clinician would have to be quite astute in making sure that sessions structured to provide hallucinatory experience are not going to inadvertently amplify or promote psychosis (Argast, Landis, & Carrell, 2001).

As for sensory alterations, simply consider under what conditions you might want to enhance or diminish someone's sensory capacities. Suggesting less auditory sensitivity to tinnitus, a ringing in the ears, or greater auditory sensitivity to hearing the stress in a spouse's voice to encourage more empathy are examples of appropriate suggestions for auditory sensory alterations.

Ideodynamic Responses

Description The powerful effects of conditioning can be observed in a lot of different ways in daily life since so much of our daily functioning is done on an automatic, unconscious level. If you had to pay attention to every single thing you did each day, by the time you got showered and dressed and ready for work it would be time to call it a day. Our automatic functioning frees our mind to involve itself in higher-order activity. The automatic functions that humans are capable of exist on at least four different levels: cognitive, motoric, sensory, and affective. Collectively, these are called the *ideodynamic responses*, a term suggesting the conversion of an idea into a dynamic response. Individually, the responses are the *ideocognitive response*, the *ideomotor response*, the *ideosensory response*, and the *ideoaffective response*. Each is an automatic response generated at an unconscious level in response to a stimulus, either external or internal.

General Applications of Ideodynamic Responses The ideocognitive response is what cognitive theorists might call an automatic thought. These are the unconscious cognitive associations triggered in clients' thought processes in response to the clinician's suggestions. Hypnotic processes employ a wide variety of procedures to encourage so-called cognitive distortions, irrational beliefs, and unrealistic expectations, as self-limiting ideocognitions, to come to the surface for identification and correction. This is especially the case when hypnosis is used in conjunction with cognitive-behavioral approaches (Alladin, 2008; Yapko, 2001b; Zarren & Eimer, 2001).

The ideomotor response is the physical manifestation of mental experience or, in other words, the body's unconscious physical reactions to one's thoughts. The Chevreul's Pendulum (described in Chapter 14) is a hokey but useful demonstration of this relationship (Lynn & Kirsch, 2006). Being a passenger in a car and moving to hit the brake is also an example. So-called body language is an entire category filled with thousands of examples (the body moves unconsciously as an analogue to what is thought or verbalized) of ideomotor responses.

The body's movements are usually so slight they remain out of awareness (i.e., are unconscious), but they can usually be observed by the naked eye. Certainly they are most easily measured with devices such as the polygraph, which can measure variables such as heart rate, galvanic skin response, and level of muscular tension. The polygraph is an example of the ability to detect measurable changes in the body that test subjects are generally unaware of as they respond to questions from the examiner.

Ideomotor responses may be facilitated for diagnostic or therapeutic purposes. Diagnostically, the clinician may suggest to clients an automatic physical response to questions. For example, one might suggest that if the response

to the question is yes clients' head will slowly nod automatically and effortlessly, and if the answer is no their head can shake involuntarily from side to side. It is not uncommon for clients to verbalize the yes response while simultaneously indicating the no response with their head. Which would you believe? (If you would be prone to believe the verbal response, I have some real estate I'd like to talk to you about purchasing … nothing wrong with it, it's just under a few feet of water …) While the ideomotor response is certainly not a lie detector, it can provide evidence of the existence of multiple cognitive controls and conflicting feelings within the client (Cheek & LeCron, 1968; Ewin & Eimer, 2006; Shenefelt, 2011).

Therapeutically, the ideomotor response can be used to facilitate dissociation, to deepen hypnosis, to serve as an indicator of responsiveness, and even to serve as a means for exchange between clinician and client when such techniques as *automatic writing* or *automatic talking* are employed. Automatic writing refers to clients' ability to write (or draw) without conscious involvement in doing so (Hilgard, 1992). Signing your name and doodling are examples of automatic writing and drawing. Automatic talking involves having clients speak without a conscious involvement in doing so (Watkins, 1987). Talking to oneself, reading aloud, and absentmindedly carrying on a conversation are examples of automatic talking. Direct but permissive suggestions are given to clients, for example, that they "can write and wait with eagerness to see what was written by your hand." Cataleptic clients can move in automatic, usually jerky, movements as they carry out ideomotor responses such as hand levitation, finger signals (suggested to clients so they can provide information or to indicate when they have finished a thought, retrieved a memory, are ready to go on, or whatever), and head nods.

Ideosensory responses are automatic experiences of sensation associated with the processing of suggestions. Having the normal range of sensation and a kinesthetic memory for what the experience of the sensation was provide the basis for the ideosensory response. When someone suggests that you can recall the experience of having peanut butter stuck to the roof of your mouth, the sensation can come back to you quite automatically as you make sense of what was suggested to you. The taste and feel of peanut butter in your mouth is immediately available to you only because of your past experience with it. The suggestion would have no effect if you had never tasted peanut butter (or if you do not have a mouth). Describing in elaborate detail the various sensory components associated with an experience allows clients to reexperience those sensations to a degree determined by such factors as the amount and type of past personal experience with it and the degree of kinesthetic awareness that individuals generally have.

Ideoaffective responses are the automatic emotional responses attached to the various experiences each person has. People have a diverse range of emotional responses to life's events, each differing in the types as well as degrees

of intensity of response. It is difficult, if not impossible, to feel entirely neutral about many experiences, especially those that are significant enough to bring into therapy. Therefore, as clients experience the suggestions of the clinician, different feelings associated with the ideas contained in the suggestions come to the surface. Buried negative feelings of hurt and despair can arise in a flash, as can positive feelings of joy and pleasure. The emotional intensity of people's responses to suggestion often catch both the client and the clinician off guard. Be ready.

Ideodynamics are simply structural components of a total experience. Every experience you have occurs on a variety of levels, each adding to the overall experience in a different and complementary way. In doing hypnosis, the ideodynamics are important variables for two important reasons. First, they reflect clients' inner experience at the unconscious levels where change is sought. Second, they are a part of the current therapeutic experience and will be the thoughts, actions, feelings, and sensory-based components of the therapy they will come to recall and rely on as the basis for change in the future.

Strategies to Elicit Ideodynamic Responses Unlike many of the other hypnotic phenomena, ideodynamic responses will arise no matter what you do. There is virtually no way clients can prevent unconscious body movements or thoughts or keep from reexperiencing feelings and sensations in response to your suggestions. In facilitating ideodynamic responses hypnotically, the issue becomes one of whether clients respond well to suggestions for specific automatic responses or not. The thoughts, feelings, sensations, and movements that the clinician suggests will be responded to more easily the greater the degree of dissociation present, since ideodynamics are defined as unconscious responses. Therefore, facilitating dissociation is a necessary first step before attempting procedures like automatic writing or ideomotor signaling.

Direct suggestions offered permissively are useful for facilitating ideodynamic responses. The following suggestions are examples of this type:

… As you listen to me describe that experience, I wonder what thoughts will pass through your awareness that might surprise even you. (ideocognitive response)

… As you let your body relax … your head begins to slowly drop downward … and let it do as it wishes. (ideomotor response)

… And as your muscles continue to relax … you can feel the tingle in that spot … (ideosensory response)

… While you remember that picture of yourself as a child … you can notice the feeling that the picture recreates within you. (ideoaffective response)

Each of these suggestions directly suggests an automatic experience not consciously created. They "just happen" as clients follow the suggestion, and they don't have to will them to happen at all.

Indirect suggestions for ideodynamic responses are also very useful, as long as the clinician chooses words carefully since the words used will engender the specific response obtained. Examples of indirect suggestions for ideodynamics include:

… As a reflex you can think you're to blame for that event happening, but a new thought will occur to you to make you seriously doubt it. (ideocognitive response)
… I don't think your conscious mind will know what your unconscious mind knows about that event until your finger has lifted. (ideomotor response)
… I wonder whether you can recall how good it feels to cool off by jumping into a cool swimming pool after feeling hot and dried out from the heat of the sun. (ideosensory response)
… It can be a great relief to find out that what you thought would be a major car repair is only a minor one. (ideoaffective response)

Preoccupying clients with the content of the suggestion facilitates the ideodynamic response, for while they project themselves into the described situation and attempt to make meaning of it their unconscious is already responding. Identifying the idiosyncratic patterns of nonverbal communication individuals use unconsciously can be a rich source of information about them. Noticing such patterns and interpreting them are two different things, however, and while I encourage noticing patterns I actively discourage interpreting them. Saying a gesture "means" this or a posture "means" that is a gross oversimplification and is more likely to be only a projection of the observer's unconscious than anything else. Too often, peoples' interpretations are simply wrong.

Ideodynamic responses are responsible for the most direct contact you will have with clients' unconscious. Doesn't that *automatically* entitle them to careful consideration?

Time Distortion

Description The experience of time is a purely subjective one, meaning you experience the passage of time in your own way at any given moment. Everyone has had the experience of doing something pleasurable and fun, and discovering that what seemed like a short period of time was actually a relatively long one: "Time flies when you're having fun." Likewise, you have no doubt had the experience of being in situations that were difficult or boring, and after checking your watch and waiting—for what seemed like 3 days—you then checked your watch again and found, much to your distress, that only 5 minutes had gone by. The subjective passing of time can seem much longer or much shorter than is objectively true, depending on your focus of attention. Such distortions of time take place in all people's experience, and like all other experiences that are subjective the experience of time can be significantly

altered in deliberate ways hypnotically with appropriate suggestions (Cooper, 1952; Edgette & Edgette, 1995; Erickson & Erickson, 1958; Kahn, 2010).

General Applications of Time Distortion Facilitating the distortion of time in clients' perception can make for a very useful therapeutic experience. Think of situations where it would be helpful to lengthen or shorten one's sense of time: When clients are in pain, for example, condensing a long period of painful existence into what seems like a very short period of time can be a most humane intervention (Bejenke, 1996; Patterson, 2010). Expanding the perception of time of comfort in between the contractions of a woman in labor can make the birthing experience a much more comfortable one (Kroger, 2008). Having a long work day subjectively seem shorter can make a difficult job a little easier to take. Having only a short period of clock time in which to take an examination yet subjectively experiencing plenty of time can allow for better performance. These are but a few potential examples of useful applications of the hypnotic phenomenon of time distortion.

Strategies to Elicit Time Distortion Approaches for facilitating time distortion can range from simply getting out of the way and letting time distortion arise spontaneously to offering direct and indirect suggestions for its deliberate elicitation. Time distortion tends to arise with no suggestions for it at all, for once people close their eyes and become absorbed in internal experience (e.g., thoughts, memories, sensations), the real world recedes into the background, the passage of time is generally unimportant, and the chance to make a realistic assessment of how much clock time has elapsed is more difficult. Try this yourself: Check the time, let your eyes close, and then let your mind drift to wherever it happens to go. Open your eyes again after what you feel is 5 minutes of clock time. How far off are you? Did you under- or overestimate? Most people in this brief exercise would think more time had elapsed than actually did. If you ever had to be silent for an entire minute as a child in school, you know how only a minute of forced silence can seem like an hour. For clients in hypnosis, though, who are relaxed, absorbed in meaningful and helpful experience, and enjoying the experience, the tendency is to underestimate the passage of time. They typically think that a 20- or 30-minute session was only 5 or 10 minutes long. It's often a convincer to people that they were, in fact, hypnotized when they discover the big difference between what the clock on the wall says and what their "inner clock" told them.

Direct suggestions for time distortion, especially when offered permissively, can facilitate the experience well. The following are examples of direct suggestions for time distortion:

… And it can seem to you as if a long period of time has gone by … and that you have had many hours of high-quality rest. (time expansion)
… An hour can seem like a minute … and time can pass so quickly … when each thought passes through your mind at a rate so fast that it's

easier to just let your thoughts pass quickly by than try to catch one. (time condensation)

… Your mind and body have been so busy here … and it takes so much time to do everything you've done … hours might seem to have passed by while you have been so preoccupied. (time expansion)

Indirect suggestions for time distortion gently plant the notion that the experience of time can be altered. Indirect suggestions (e.g., "I wonder how very few minutes have gone by during this relaxed time …"), stories containing examples of experiences where time was distorted (e.g., "I was so busy I didn't even notice how much time had elapsed"), conversational postulates (e.g., "Are you surprised at how much you've accomplished in just a few minutes?"), and double-binds (e.g., "Did it seem like a very long time or just sort of a really long time to you?") are all capable of facilitating time distortion. The following suggestions provide another example of each:

… Keeping track of time is so difficult sometimes … and right now it's hard to know whether 5 minutes or 6 minutes have gone by … and how can anyone really know whether only 5 1/4 minutes have gone by or 5 1/2 … or 5 5/8 or 5 3/4 minutes have gone by? (indirect suggestion for a constricted experience of time)

… I worked with a client not long ago who felt so uncomfortable when she first came in … her problem bothered her a lot … but when she closed her eyes and let herself listen to me … deeply … she forgot to notice how much time went by … and she let herself relax so deeply … It seemed like hours of comfort … soothed her mind and body … and she felt so good … for a long time afterward. (metaphor regarding an experience of time distortion)

… And you've been so comfortable sitting and listening to me, haven't you? … That's right … and it isn't easy to know how long … very long … a period of time has passed, is it? (conversational postulate for time expansion)

… And now I wonder whether you realize how fast and short this period of time has gone by … and you can guess if you'd like … would you say it's been only 5 minutes or would you say it's been as much as 7? (forced choice orienting the person to a specific time span)

In the first example, by getting so specific about how much time has elapsed and framing all the choices within a short period of time, one can help clients become oriented to that time frame and thus feel as if a lengthy process actually took only 5 to 6 minutes. If the clinician wants to expand time, the frame used can be an exaggerated one (e.g., for a 10-minute hypnosis session, the clinician can suggest how difficult it is to know if 20 or 20 1/2 minutes went by). In the second example, a metaphor is offered that lets clients know they can be comfortable for what feels like a long time by being in hypnosis

through the building of an identification between them and the person in the story. In the third example, the conversational postulate is employed; by asking clients to realize how difficult it is to assess the length of elapsed time, the presupposition is that a long time has passed. In the last example, clients are forced to choose between two times that are both much shorter than the actual time elapsed. Time can be expanded by making the forced (double-bind) choices much longer than the actual time elapsed.

When clients disengage from hypnosis and discover how distorted their perception of time has been, they know they have experienced something out of the ordinary. The result can be a new respect for the complexity and sophistication of their inner world. A boost in self-esteem accomplished so easily is one of the most positive dimensions of doing hypnosis.

ENDING THE HYPNOSIS SESSION

Closure and Disengagement

As good as it feels to be in hypnosis, eventually you have to end the session, disengage from the hypnotic experience, and move on with your day. Closure and disengagement is the final stage of hypnotic interaction. Clients may indicate a readiness to disengage through a diminished focus of their attention and by beginning to move and stretch. The clinician has to make a decision at the moment of observing such signs as to whether the work is done for that session or whether their initiation of disengagement is some form of avoidance that can be addressed therapeutically.

The clinician is directing the therapy session and should generally be the one to decide when initiating closure and disengagement is appropriate, just as he or she decides when the induction of hypnosis is appropriate. In deciding when closure and disengagement is appropriate, the clinician can also decide on what the manner of closure and disengagement will be. When and how to close and disengage is a matter of individual clinical judgment, based on the overall treatment plan and the accomplishments of that specific session. The clinician has, by this time, employed a suggestion style and structure in his or her approach to the clients, and the closure and disengagement can be consistent with these. If the clinician has been relatively direct throughout, he or she can offer such suggestions as the following for closure and disengagement:

> … You can bring this experience to a comfortable close and bring yourself out of hypnosis at a rate that is comfortable for you … taking as much time as you'd like to to comfortably complete this experience for yourself.

… When you're ready, you can open your eyes and reorient yourself to the here-and-now, feeling relaxed and refreshed.
… When you open your eyes in about 1 minute and rediscover the outside world … you'll be able to notice how good it feels to have been in hypnosis.

Most direct approaches to closure and disengagement (traditionally called *awakening*, an unfortunate choice of terms since the person wasn't asleep) have employed an authoritarian counting method, such as, "I'm going to count to three and snap my fingers and you will then be wide awake." Such an approach is not particularly respectful of clients' need to disengage from the hypnotic experience at their own rate. Expecting clients to respond to an arbitrary count and come out of hypnosis simply because you want them to does not allow them whatever time they may want to comfortably complete the experience for themselves. Furthermore, expecting any human being to respond to a finger snap is simply degrading and therefore undesirable.

If the hypnosis session has been an informal, spontaneous one, the clinician can choose to be consistent in his or her approach by offering indirect suggestions for closure and disengagement. The following suggestions are exemplary of such an approach:

… And I wonder whether you've realized how comfortable it has been to let your mind consider that possibility … and that can certainly be an *eye-opening* experience.
… And after a nice rest such as the one you've just had you can certainly *alert yourself* to the joys of living.
… Did I tell you how I learned about that? … I was so preoccupied with myself that I didn't notice things around me much … but you can become less self-absorbed and move around in the world and notice things outside yourself … *opening your eyes* to new possibilities.

In deciding on the when and how of disengagement, the clinician can consider such factors as whether amnesia is desirable to suggest and what types, if any, of posthypnotic suggestions might be offered. How the hypnotic experience is concluded will have a significant impact on clients, since human memory is generally stronger for the most recent events, a phenomenon learning theorists call the *recency effect*. In other words, the feeling clients have as they disengage from hypnosis are the feelings they are most likely to associate with the whole hypnotic experience. This is another reason it is usually the best option to allow them the time they want or need to complete their processing of the events of the hypnosis session. Letting clients disengage at their own chosen rate allows them the opportunity to feel relaxed and unhurried under your care.

CONCLUSION

This chapter has described in detail the most basic building blocks for the therapeutic applications of hypnosis. Clinical interventions will always involve some or all of these hypnotic phenomena, and it is therefore imperative that you be clear about what each of these subjective experiences is really about. Before you can apply them in meaningful ways, it may be most helpful to you to first spend some time observing these experiences as they arise in daily living, particularly if you attempt to uncover what served as the trigger for the phenomenon. Such careful observation of the range of human experiences occurring routinely can make eliciting them in hypnosis easier to accomplish.

As building blocks, the various hypnotic phenomena can be arranged and rearranged in an unlimited number of configurations. The process of planning a specific intervention for particular clients can involve the development of a hypnotic strategy. You can decide which hypnotic phenomena would be useful experiences for them to have. More specifically, you can decide the types of orienting ideas to be presented, the type and style of induction to be used, which hypnotic utilizations (therapeutic strategies) to use with special consideration for their content, style, and degree of complexity.

With the various hypnotic phenomena serving as the foundation on which to build the intervention, the task of the clinician—to design and deliver such experiences in a meaningful way—is a complicated one. This task is considered in greater detail in the next chapter.

FOR DISCUSSION

1. What is your reaction to discovering some of the everyday aspects of hypnotic phenomena? Does it make it easier or harder for you to think of hypnosis as something special in therapy?
2. What is your opinion about past-life regression (regressing someone hypnotically to a previous incarnation), hypnotic extrasensory perception (ESP; amplifying it hypnotically), and other paranormal applications of hypnosis? What is the basis for your opinion?
3. How can each of the hypnotic phenomena be seen in the various mental disorders? (For example, a dissociative identity disorder involves the dissociation of personality parts and may also involve amnesia for the existence of each part.)
4. In what instances, if any, might facilitating any of the various hypnotic phenomena be contraindicated? Explain your reasoning.
5. How might you use age progression to assist your learning of hypnosis?

THINGS TO DO

1. List 10 routine contexts in which each of the hypnotic phenomena arise. What factors seem to precipitate these phenomena arising?
2. During an age regression process, have your subjects write their name while at different ages. Do you observe differences in writing style that seem age-appropriate? What do you conclude?
3. Make a list of the 20 most significant events in your development. Which ones would you characterize as being positive? Which negative? Which ones seem to have the most emotion attached to them? Why? Does this make them easier or harder to recall for you?
4. Check with local hospitals to find out what their policies are regarding the use of hypnotic anesthesia in their operating rooms. What do you find out? Locate and arrange to interview any local physicians who do surgical procedures employing hypnotic anesthesia.

CHAPTER 20

DESIGNING AND DELIVERING HYPNOTIC INTERVENTIONS IN TREATMENT

Knowing the basic forms of suggestion structure, the fundamentals of hypnotic induction, and the potential shifts in experience associated with various hypnotic phenomena, we can now focus more specifically on developing hypnotic and strategic approaches to treatment. In this chapter, I consider some of the practical foundational principles for introducing and integrating hypnosis into the therapeutic context. How will you decide what exactly to say to clients who are suffering when you know that each word, each phrase, you employ has the potential to make a positive difference?

The key word in the previous sentence is *potential*. There should be no illusion on your part that if you say everything just "right," as if you could even if you desperately wanted to, you will be successful. As you have learned by now, there are many factors influencing the outcome of an intervention, hypnotic or otherwise. Some of these factors are in your control, such as your choice of wording and your sense of timing, and some of these factors are not in your control, such as clients' idiosyncratic interpretation of your meaning, the side effects of medications they may be taking, and unexpected outside distractions. This chapter is meant to provide some guidance in helping you control the things you can to increase your potential effectiveness while applying hypnosis in treatment.

I'm a strong advocate for having a well-considered and well-organized treatment plan. I'm aware there are those who advocate the "trust your unconscious to know what to say" philosophy, but being thoughtful about the goals of sessions and the means to achieve those goals doesn't preclude being spontaneous or intuitive in the course of treatment as well. I appreciate Thomas Jefferson's words: "I'm a great believer in luck, and I find the harder I work the more of it I have." In the clinical context, being deliberate about defining the therapeutic relationship, the agreed upon goals of treatment, and the benchmarks of progress, and having the skills to adapt to and utilize whatever happens to arise in the course of treatment is the artistry of good therapy and good hypnosis. Clinical skill counts for a lot, even though it doesn't account for everything, and many of the considerations in this chapter are meant to enhance your clinical skills in applying hypnosis.

DOING HYPNOSIS VERSUS BEING HYPNOTIC

Many practitioners of hypnosis know how to perform hypnotic techniques. However, I believe there is an important distinction to make between *doing* hypnosis and *being* hypnotic. Someone reading an impersonal script to a client may be doing hypnosis, but I don't believe he or she can necessarily be considered hypnotic. Someone who is detached from the client and the process, who has the idea that what he or she says is less important than the person's susceptibility measure, is not likely to be very hypnotic. Being hypnotic means being able to fully engage the person, being so attuned and connected to the client that you are difficult to ignore or take lightly because what you're doing and what you're offering is so relevant and absorbing.

Think about those people who grab and hold your attention—the people you don't want to take your eyes off. What about them grabs you and holds your attention? Whatever that quality is, that's hypnotic, even though they aren't necessarily doing hypnosis. When are you hypnotic? Are you aware of those special times in therapy when your clients seem riveted to your every word?

Being hypnotic means engaging purposefully with people, accepting the responsibility for being an agent of influence and change, and striving to use your capacity for influence intelligently and sensitively. Being hypnotic also means knowing that the capacity for being absorbing, engaging, and influential doesn't happen only when formal induction takes place. Being hypnotic simply means incorporating hypnotic principles of focusing people and introducing positive possibilities to them into your very way of being and is thus revealed through each interaction to one degree or another.

THE SKILLS OF A CLINICIAN

The skills needed to be an effective clinician, in contrast to those needed to merely perform an induction, are substantial. These include a broad knowledge of current clinical literature, an ability to relate to clients and to form a therapeutic alliance, and an ability to organize and direct a well-structured intervention. These are all complex skills requiring significant investments of time and effort to develop and help define the true professional.

Who we are as people is the foundation onto which the veneer of our clinical training is later glued. Consider for a moment why you structure your clinical practice the way you do. What does it say about you as a person that you maintain your individual philosophy of treatment, are attracted to and strive to practice well a particular style of therapy, and practice in such a way as to even try to lead your clients to believe as you do, however directly or indirectly you may do that?

This is hardly a new concept. We've known for a very long time that we get attracted to and practice therapy, including our hypnotic interventions, on the basis of what we subjectively find appealing. Someone goes to a hypnosis workshop and learns about and experiences an "inner sage" induction technique, for example, discovering some previously untapped inner wisdom, and thinks it was an inspiring experience. So he goes back to work with a new enthusiasm and starts doing "inner sage" techniques with almost every client. Or someone goes to a conference on the new and controversial "XYZ Disorder" and then starts seeing it in clients never previously known to have it. As you've already discovered in the Frame of Reference sections throughout this book, the gifted experts all have their own viewpoint, just as you have yours. And yours will be the determining factor in whether and how you apply clinical hypnosis.

Ideally, our personal backgrounds and interests should not be the primary basis for designing and delivering our interventions, hypnotic or otherwise. In the real world, however, all of our clinical training prepares us to focus in on "this" but not "that" when we interview our clients, so we may understand what's going on "this" way and then treat it "that" way. Having a philosophy or belief system to provide you a coherent framework is both necessary and desirable. Perhaps where clinicians sometimes err, though, is when they see things only one way and don't stretch themselves to consider how other perspectives might help in understanding and addressing the problem. Almost any problem can credibly be understood and treated from many different viewpoints. It seems important, to me at least, to distinguish between the facts of a case and the interpretations or inferences you might make when designing your intervention so your inferences don't become dogma.

The rest of this chapter proceeds with the necessary assumption that you have created a therapeutic context in which your clients are amenable to

participating in therapy in general and hypnosis in particular. Now we can focus more directly on how to design and deliver effective clinical hypnosis sessions.

STRATEGICALLY DESIGNING CLINICAL HYPNOSIS SESSIONS

In conducting psychotherapy with people for nearly 4 decades now and having conducted who knows how many thousands of hypnosis sessions, my thinking about therapy has become simpler rather than more complex over time. I've become less interested in the philosophies of therapy and the complexities of various theoretical formulations and more interested in the "bottom line" of what effective clinicians actually say and do. So often, what they say they do is markedly different from what they actually do.

With simplicity in mind, there are four basic questions I pose to myself when I am working with a client. There are obviously many more I pose as well, but there are four questions in particular that help me to organize my therapies and to develop a clearer focus on what I want to address in treatment and how I want to address it:

1. What are the client's goals? And, as a corollary, what is an appropriate order for addressing them?
2. What are the specific personal resources the client will need to be able to accomplish the goals?
3. Does the client already have the necessary resources in his or her repertoire or history and primarily needs help mobilizing them? Or does the client not have those resources and needs assistance in first identifying then building them?
4. How will contextualization be accomplished; that is, how will the necessary resources be made available in the appropriate contexts?

The first question is about goals. Hypnosis is a directive approach, and its use presupposes a purpose, a goal to strive for. In the next section I will focus on the issue of goal setting since it is the first step in the process and creates the framework for all else that follows.

The second question is about resources. Addressing this second question skillfully presupposes that you know what skills would be necessary to accomplish some goal. Unfortunately, the language of therapy is often so abstract that clinicians sometimes lose track of precise meanings and the concrete actions necessary to produce a desired effect. We speak the psychobabble that employs phrases such as *building self-esteem, increasing ego strength,* and *building permeable boundaries* and then act as if these phrases actually mean something. They represent experiences, and it is essential to know what experiences they represent. The task for me in answering this second question

is having a concrete definition of what exactly individuals need to be able say or do within themselves or out in the world that would make achieving the goal possible. If there aren't specific steps to follow, then it isn't a goal. Rather, it's merely a wish.

The third question is about where the necessary resources will come from once they've been identified as necessary. Can anyone do anything if they just have the proper motivation; that is, "Where there's a will, there's a way"? I think that is a potentially destructive notion because it defines all problems in terms of motivation alone. It would be more accurate to say, "Where there's a will, *maybe* there's a way." Motivation without the necessary abilities frustrates people, giving rise to the sense of "being stuck." Both motivation and ability matter in treatment, and neither alone will get the job done. Thus, I first want to assess what salient abilities clients might have that they aren't using to their detriment, and then I want to create an experiential bridge to them that makes them accessible. Such bridge-building is a prime use of hypnosis. If clients don't have the necessary abilities to accomplish what they want or need to accomplish, then it becomes my task in treatment to provide a structured means for teaching those skills and making them learnable. Teaching skills is another prime use of hypnosis. Is there any doubt people learn more easily when they are focused and relaxed?

The fourth question is about contextualization. Having resources is one thing, but using them effectively at the appropriate time is another. As you learned when studying posthypnotic suggestions, the chief function of the posthypnotic suggestion is to establish an association, a link, between the desired response and the appropriate context for that response. Of course, there are also other ways of building this association besides the posthypnotic suggestion. You can employ role-playing strategies, cognitive rehearsals or what some call success imageries, and homework assignments for the same purpose. The goal at this stage is simply to take what is being learned in hypnosis and therapy and be able to apply it effectively in the course of daily living.

Each of these four questions naturally raises many others in the treatment process that are also helpful to consider. But I find these four questions especially helpful in helping me to get clear about what I want to say to my clients during the hypnosis session, the first step in designing hypnotic interventions. Perhaps you'll find them helpful, too.

HYPNOSIS AND THE TARGETS OF TREATMENT

Clients routinely present to clinicians statements such as, "I just want to feel better," or "I just want to have a good relationship." Statements such as these are so global as to be nothing more than mere wishes. They are not well-defined targets for clinical intervention. If a clinician is unclear as to what he or she specifically needs to address, the intervention will likely go nowhere.

FRAME OF REFERENCE: DAVID SPIEGEL

David Spiegel (1945–) is associate chair of the Department of Psychiatry and Behavioral Sciences and Willson Professor in the School of Medicine at Stanford University. He is also the director of the Psychosocial Treatment Laboratory and medical director of the Center for Integrative Medicine. He has been on the academic faculty at Stanford since 1975. Dr. Spiegel earned his bachelor's degree at Yale and completed his medical and psychiatric training at Harvard. He is a gifted researcher and teacher and a powerful presence in the field as he advocates for doing scientifically informed hypnosis and psychotherapy.

Dr. Spiegel is the author of more than 500 publications, including his landmark study (Spiegel, Bloom, Kraemer, & Gottheil, 1989) on the effects of psychosocial treatment on the survival of patients with metastatic breast cancer. This research suggested that supportive/expressive group therapy in women with terminal disease improved their quality of life and, even more dramatically, increased their survival time. The majority of studies, including two recent ones involving breast cancer and lung cancer, confirm the finding. As Dr. Spiegel (2011) pointed out in a recent commentary in the *Journal of the American Medical Association*, psychosocial effects on cancer survival seem clearest in the most difficult situations, as in end-stage illness when medical treatments are least effective. His ongoing research in this critically important domain eventually led to his popular book *Living Beyond Limits: New Hope and Help for Facing Life-Threatening Illness* (1995), which provided further data and perspective as well as coping skill guidelines for women living with breast cancer and their families. His most recent book is called *Group Therapy for Cancer Patients* (2000) and is coauthored with Catherine Classen. Dr. Spiegel likes to remind people that his work shows that survival is not merely mind over matter but that mind does matter. His research has earned him many prestigious awards and the highest respect from his peers.

Dr. Spiegel is at the forefront of research in the fields of psychosomatic medicine and clinical hypnosis. His professional interest in hypnosis began early in his career, influenced in part by his well-known psychiatrist father, Herbert Spiegel, whom he had seen demonstrate hypnosis on many occasions. He took his first course in hypnosis while at Harvard, and in 1978, soon after completing his residency and postdoctoral fellowship, he coauthored with his father a book that many in the hypnosis community consider a classic: *Trance and Treatment* (Spiegel & Spiegel, 1978/2004). In this volume, the authors described a diagnostic system and means for evaluating hypnotic responsiveness called the Hypnotic Induction Profile (HIP), described in Chapter 14, as well as diverse clinical applications of hypnosis. Dr. Spiegel coauthored a paper published in the *American Journal of Psychiatry* (Kosslyn, Thompson, Constantini-Ferrando, Alpert, & Spiegel, 2000), described in Chapter 4, that received an extraordinary amount of attention for the extraordinary findings: Hypnotized research subjects given suggestions to hallucinate color while viewing black-and-white photographs had the parts of their brain used for color processing "light up" in brain scans. Conversely, when the subjects were instructed to have the illusion of draining color from color images, these same brain regions showed decreased activity. He calls this his "believing is seeing" experiment. This remarkable finding suggests strong neurophysiological processes evident in hypnotic responsiveness, helping move the field a step closer to understanding the neuroscientific underpinnings of the phenomenon of hypnosis. He is currently utilizing functional magnetic resonance imaging (fMRI) to identify neural networks at work during the hypnotic state and to distinguish the neural functioning of high versus low hypnotizable individuals.

On hypnotizability testing: "Hypnotizability testing turns an induction into a deduction. You acquire useful information about a person's ability to respond to hypnosis in 5 minutes or less. By standardizing your input, you maximize what you can learn about the variance in responses to it, and use this to direct your approach to the patient and teach the patient about their responsiveness. You also reduce tension in the initial hypnotic encounter—your role is to assess rather than talk the person into a trance, and they are exploring their ability, rather than either complying or resisting."[1]

On spontaneous hypnosis and hypnotic ability: "Hypnosis occurs spontaneously, even without a formal induction, as research on absorption indicates. Moments of 'flow,' peak performance, and intense pleasure have self-altering and intense attention as one component, and are thus hypnotic-like. While many people have such peak experiences, and some have dissociative experiences, not everyone does. Research indicates that hypnotizability is as stable a trait as IQ and involves intense and focused attention. There is no reason human mental experience should be any more equally distributed than human physical traits."[2]

On psychosocial support, hypnosis, and breast cancer: "There is evidence from some but not all studies that participation in group therapy increases survival time with breast cancer. It has not been proven that hypnosis is a key component to this effect. However, hypnosis is extremely helpful in reducing cancer-related

pain and anxiety. Cancer can be understood as a stressor, and focused attention coupled with dissociation is very helpful in managing stress, ranging from anxiety about dying to getting through difficult medical procedures with less pain and anxiety and even more rapidly."[2]

On different hypnotic styles: "While each clinician needs to sample various approaches and find one that makes sense and seems most useful to patients, I feel an obligation as an investigator and teacher to find and test the crucial elements in treatments that work. I feel there has been much mystification of hypnosis over the centuries and that it is most likely to be used (and used well) in medicine when we distill the crucial elements and use them. I find that patients make good use of clear and direct approaches that invite their collaboration through facilitating their understanding of the treatment approach."[1]

On clinical skills underlying the use of hypnosis: "It is crucial for clinicians to have basic skills in diagnostic assessment and knowledge of various treatment approaches that can be utilized both with and without hypnosis. It is crucial to be a primary professional (e.g., psychiatry, psychology, dentistry) rather than a hypnotist. Then it is most helpful to learn to communicate clearly and compassionately and to use your relationship with the patient as a therapeutic tool."[1]

On excitement and disappointment with the field: "I have been excited to discover, along with other colleagues, the profound effects hypnosis can facilitate in affecting brain function, such as processing color perception and pain, and body function, such as asthma, gastric acid secretion, and warts. My biggest disappointment is the enervating battles over sociocognitive versus state explanations of hypnosis and other unnecessary turf battles. The phenomenon is resilient and interesting enough that there is room for many approaches to compete productively for explanatory power. In an era of frustration with the pace of medical innovation in treatment, we need to find a way to reliably incorporate the power of hypnosis to help people control pain, anxiety, bad habits, and various physical dysfunctions into standard treatment. Hypnosis can amplify self-management of many common and serious medical problems. Hypnosis, the oldest Western conception of a psychotherapy, has been nipping at the heels of mainstream care for centuries. We need to take it seriously and use it well."[1]

[1] *Personal communication, August 5, 2002.*
[2] *Personal communication, January 23, 2011.*

Yogi Berra, a colorful former professional baseball player who endeared himself to the public through his routine mangling of common phrases, famously said, "You got to be careful if you don't know where you're going, because you might not get there." He was right, of course, in emphasizing the merits of deliberateness in having a well-defined target. Yet somehow a culture of magical thinking has arisen around the practice of hypnosis, promoted by those who are attracted to the rather idealistic—and self-flattering—notion of an

organized, wise, and benevolent unconscious: Clinicians are told to "trust your unconscious" to (magically) develop an appropriate intervention, while the client is told to "trust your unconscious" to (magically) learn what is relevant.

I don't suggest you rely on a "trust your unconscious" approach. Instead I think there should be specific information you gather about clients' experiences, well-defined goals you articulate and agree upon, and sensible strategies to employ in reaching them. In my opinion, the times hypnosis in particular and therapy in general work best are when there is a target to be hit and a well-defined means for doing so within the context of a good therapeutic relationship.

I can think of no one who is a better role model of the merits of deliberateness than David Spiegel. Dr. Spiegel is at the cutting edge of clinical research and practice, and is widely respected as an advocate of responsible practice based on a solid knowledge of the research.

DESIGNING INTERVENTIONS: WHERE TO FOCUS FIRST

In real-world circumstances, unlike participants in traditional therapeutic efficacy studies who may be excluded from the research if they have additional problems beyond the single condition being investigated, clients typically have multiple problems, even multiple diagnoses. Faced with multiple problems to address, clinical judgment requires making a decision about where to begin. Not all problems are equal. Some symptoms are generalized throughout clients' lives, and some are specific to particular situations. Some are merely annoying, but some are clearly dangerous. Some are relatively easy to resolve, and some are refractory.

The first priority, of course, is what's urgent, and urgency is governed by hazard potential. Suicidal ideation, drug abuse, and reckless behavior that endangers one's life or the lives of others are just a few examples of when clinicians must establish an order of priority for intervening that one might not otherwise choose if the symptoms or problem behaviors posed no immediate danger.

Building Therapeutic Momentum and Response Sets

Where to begin, though, if no symptoms or behaviors are in urgent need of immediate attention? Generally, it is best to begin where you can generate some rapid symptom relief and thereby start to build a positive momentum in treatment. One of the most underemployed but useful constructs in applying clinical hypnosis is called the *response set* (Erickson & Rossi, 1979), discussed in detail previously.

Building a response set means building a momentum of responsiveness. For example, if I offer someone four consecutive statements I know she will agree

with, what is her most likely response to my next statement? It's likely to be agreement. For example, if I say, "Each person is unique as an individual; … Human experience is often complex; … People frequently have more resources than they realize; … Sometimes it feels good just to sit and relax …"—all agreeable statements—where does the momentum of responses carry her? Most likely into the realm of agreement for the next statement.

In the practice of clinical hypnosis, then, effectively utilizing this principle means structuring interventions to go from general to specific. Thus, before giving individuals a specific suggestion to develop an age regression, for example, I would first offer a series of general suggestions or truisms about memory that I know they would agree with, such as, "Each person is capable of remembering many different experiences … Some memories are much more vivid than others …," which gradually lead them in the direction of later remembering or even revivifying a specific memory.

Similarly, in the same way responsiveness to hypnosis can build over the course of the session, so can responsiveness to the therapy. Of the multiple problems one might be asked to address, it is generally best to start with the problems that can be most easily resolved quickly, thereby establishing a momentum of therapeutic progress. Furthermore, by getting some success early on, the risk of clients dropping out of treatment prematurely is reduced. So often, what leads people to drop out is low frustration tolerance, the need for relatively instant success, or loss of interest in what seems like a futile endeavor.

DESIGNING INTERVENTIONS: RISK FACTORS AS INTERVENTION TARGETS

Comprehensive treatment must take the risk factors for other problems and for relapses into account as well as current symptoms. A risk factor is any factor that increases the probability of a particular disease or disorder occurring. The risk factors to be targeted in treatment, along with their associated symptoms, represent some of the deeper applications of hypnosis and psychotherapy. To ignore underlying risk factors and focus only on clients' symptoms is a relatively superficial intervention, addressing only the problem's content but not its structure. The content refers to the details (i.e., the what) of the problem, while the structure refers to the process (i.e., the how) of how the symptom is produced.

Key risk factors can exist in any of scores of areas of the lives of individuals, such as family history, diet, level of physical activity, number and type of social connections, personal habits (such as smoking or drinking), drug use, lifestyle, beliefs, coping skills, problem-solving skills, and work environment. Risk factors may be addressed singly or in combination.

DELIVERING INTERVENTIONS: WHAT ABOUT USING HYPNOSIS IN THE FIRST SESSION?

Depending on the clinician's level of skill in interviewing clients and readily assimilating the information into a sensible treatment plan, a clinician might well have enough information to formulate a meaningful hypnotic intervention, even in the very first therapy session. Some clinicians believe one should have a strong rapport and therapeutic alliance built over many sessions before doing hypnosis. This is usually out of the fear that hypnosis might be introduced too early in the treatment process and somehow harm the therapeutic alliance. I believe that position is too limited. I would suggest instead that one can often use the hypnosis itself as a means to build the necessary rapport and therapeutic alliance with clients. In fact, I demonstrate this process in *The Case of Vicki*, a woman I had just met for the first (and only) time, as well as in so many of the other single-session published clinical demonstrations I regularly conduct.

The ability of hypnosis, even when superficially applied, to reduce anxiety, lower agitation, and reduce ruminations are some of the best reasons to use hypnosis early on in treatment. By demonstrating to clients that their symptoms are malleable, the clinician can effectively build positive expectations for therapy that significantly increase the likelihood of the therapy's overall success (Kirsch, 1990a, 2000, 2001; Wagstaff, David, Kirsch, & Lynn, 2010). The clinician's responsibility, even in the very first session, is to facilitate hope and meet the need for at least some relief as quickly as possible. Hypnosis can help do both.

DELIVERING INTERVENTIONS: INTRODUCING HYPNOSIS TO THE CLIENT

Making the transition from clinical interviewing and establishing rapport with clients to beginning an actual hypnotic intervention is easier than many people seem to think. You can interview clients and then well into the session, assuming you want to do hypnosis with them, say something such as the following as a lead-in to the hypnosis:

> I've been listening intently to you now for the last half-hour or so, describing your symptoms and problems, and how absorbed you have been in just trying to manage. I've been impressed by your suffering and despair, and it's obvious to me that you want things to change. Having been so focused on and absorbed in all the most hurtful thoughts and feelings, it seems obvious to me how valuable it would be for you to start to consider and then get absorbed in different thoughts and feelings that can help

> you feel better. You came here knowing it would be important to get absorbed in a different way of looking at things, and to help you start to get absorbed in a different way of thinking and feeling you can just let your eyes close and focus yourself on some of the possibilities I want to describe to you.…"

And thus the hypnosis session begins. I cannot think of a single instance in all my years of practice in which clients have refused to participate or were even reluctant to join the process when I introduced the purpose of focusing in this way. Clients are typically looking for direction and feedback, knowing something has to change but typically unclear as to what.

There is another style for introducing hypnosis to clients, of course, a much more conventional and structured one in which the clinician asks them whether they have worked with hypnosis before and how they would feel about working hypnotically in the therapy. The clinician draws out existing attitudes about hypnosis, identifies and corrects any misconceptions, and establishes both cooperation and expectancy by describing what hypnosis is, how it feels to be hypnotized, and what the potential benefits of hypnosis are in his or her particular case (Barber, 2008; Gibbons & Lynn, 2010). Some clinicians even go so far as to have clients sign a release form authorizing hypnotic treatment as tangible evidence of informed consent.

DELIVERING INTERVENTIONS: CHOOSING YOUR HYPNOTIC STYLE

This section briefly addresses the issue of hypnotic style, encouraging you to consider whether you want to be more direct or indirect, more positive or negative, more content or process oriented, and more authoritarian or permissive in the way you deliver your suggestions to a specific client. I recommend you choose your style based on clients' patterns of self-organization, not from some invariant formula or script. The idea is to be fluent in all styles and to draw upon them flexibly as client patterns dictate.

That people differ in their responsiveness to hypnosis is a given. What that means to clinical practice, however, is still wide open for discussion.

More efficacy or hypnotizability data gathered from research populations won't help us be better humans doing clinical hypnosis with a given individual. There is simply no substitute for having the range of skills to formulate both direct and indirect suggestions, both positive and negative suggestions, both process and content suggestions, and both authoritarian and permissive suggestions. Having the range, the flexibility, to impart information and perspective in a variety of ways is what clinical artistry is about. Thus, arguing over whether direct or indirect suggestions are superior to the other is a colossal waste of time when we should already have reached the understanding that

no suggestion, direct or indirect, is powerful or useful until clients choose to respond to it.

DESIGNING INTERVENTIONS: A GENERIC STRUCTURE FOR A CLINICAL HYPNOSIS SESSION

The structure of hypnosis sessions varies far less than their content. If we consider the structural elements necessary for a formal hypnosis session to take place, we can create a "generic structure" of primary components. Such a generic structure is contained in Table 20.1.

As you can see from the table, the generic structure provides a skeleton framework for your session. Your decisions as to session goals and content, such as which induction to employ in what style of suggestion or what problem theme to address with which kinds of suggestions, produce the variations in one client's treatment compared with another. So even though you may be treating five different people for depression, what you actually say to them individually will vary dramatically depending on what their individual needs and patterns of self-organization are (Yapko, 1988b, 1992, 2001a, 2006a, 2010). Let's go through the generic structure, component by component, so you may be clear about what's happening at each stage of the process.

Orient Clients to Hypnosis

If you intend to do hypnosis with your clients, at some point in the interaction you will want to shift their attention away from wherever it has been focused and redirect it toward creating a state of readiness to begin the process of

Table 20.1
A Generic Structure for a Hypnosis Session

Orient the client to hypnosis
Perform induction procedure
Build a response set
Introduce therapeutic theme #1 (i.e., problem, goal)
Provide suggestions addressing the theme
Ask about derived meanings
Introduce therapeutic themes #2 (#3, etc.)
Provide suggestions addressing the themes
Ask about derived meanings
Provide posthypnotic suggestions (contextualization)
Provide closure
Suggest disengagement

hypnosis. A statement as clear and direct as, "Now that you've had some time to talk about this problem, it seems like a good time for you to start to focus on getting comfortable so we can do some hypnosis," is usually a good way to start the process.

Perform Induction Procedure

Encouraging clients to position themselves comfortably, to breathe comfortably, to let their eyes close, to focus and listen, and simply to relax are all the stepping-stones to beginning the induction. Which induction you use is, of course, a matter of clinical judgment based on all the considerations detailed in previous chapters. Whatever secures and directs clients' attentional processes will serve perfectly well as an induction procedure.

Build a Response Set

The importance of building a momentum of responsiveness in clients cannot be overstated. In fact, I have already indicated that I consider this the most important step of the entire therapeutic process because if they aren't encouraged to be responsive, then not much else is likely to happen when you offer subsequent suggestions.

Most people simply can't produce hypnotic phenomena such as analgesia or regression instantly on demand. But given time and an atmosphere that encourages exploration, people can usually develop hypnotic responses sufficient for therapeutic purposes. Paying attention to the deliberate building of response sets is simply a way of increasing the likelihood of catalyzing a positive response to the hypnotic experience.

The general pattern for building a response set is this: before asking clients for a specific response, you present ideas in a general and irrefutable way that indicates such a response is humanly and even personally possible. Thus, before attempting to generate an analgesia in a specific part of clients' body later in the hypnosis session, for example, it is helpful to first get them comfortable with and attuned to the notion that noticing or even creating variations in their perception about their body is possible, suggesting for example, "Sometimes your body feels tired, and sometimes it feels well rested …". In this example, clients are oriented in a general way to the irrefutable recognition that their experience of their body varies. Establishing that point serves as a stepping stone to the larger goal of the session, namely, creating a specific variability in sensation with suggestions for analgesia (described in Chapter 25). In essence, you're saying, "Your experience of your body varies, and since it does it can vary like this." The response set moves clients in the direction of the larger therapeutic goal without yet demanding a specific response from them.

Introduce Therapeutic Theme 1

What do you want to say to individuals that is meant to be helpful? What is the clients' misperception or self-limiting belief you want to address? What empowering resources do you want to associate clients to? When you are clear about what the helpful message is you want to convey, then you have established the topic of your therapeutic theme (McNeilly, 2001). For example, if a client believes he is a victim of circumstances and seems oblivious to proactive beneficial choices he could make, if you simply say to him, "You could make proactive beneficial choices," he will likely be entirely unimpressed. By employing hypnosis, however, you have the opportunity to get that same important point across in a much more focused, experiential, and powerful way. So you might introduce to him the salient therapeutic theme regarding "the importance of knowing what's controllable," with the goals in mind of motivating him to make deliberate choices and teaching the skills of recognizing what's in his control as a precursory step in the direction of being proactive in living life well. The message you want to get across in 25 words or less is, "Quit acting like you're a victim and take charge of your life." But to help soften that too abrupt and emotionally threatening message, it needs to be said in a way that's more comfortable and easier for clients in a victim mind-set to absorb. So I might introduce that theme more gently by saying something such as:

> … As I continue to talk to you about different ideas and different possibilities you might well become aware of how different people experience life in very different ways … Some people think life is just whatever happens to them, while others think they can create whatever kind of life they want … Isn't it interesting how some people think they have control over the quality of life and others feel they don't … Sometimes people overestimate how much control they have and try to control things they really cannot … while others sometimes underestimate how much control they have and don't try to control things and make good choices they really could … It can be very confusing to know what's in your control and what isn't, don't you think? …

I have now introduced the theme and focused clients' attention on the therapeutic issue of controllability. A more direct approach at this stage would be to say something such as, "You see yourself as having no control over what goes on in your life. But you have more control than you realize. I want to talk to you about ways you can begin to take charge of your life." The next step in the process then builds on whatever therapeutic theme you have introduced to them at this stage in the process.

Provide Suggestions Addressing the Theme

Once you have introduced the therapeutic theme and drawn clients' attention to the problem you intend to address, the next step is to address the theme by offering suggestions that can help resolve the problem or accomplish the therapeutic goal. This is the stage at which your therapeutic strategy is implemented. Are you going to try to teach clients a specific skill that can empower them? Challenge a self-limiting belief or misconception they hold as true? Share a meaningful observation or philosophy about life you believe they can benefit from? Try to alter a perceptual process they engage in? Whatever your intended use of hypnosis, hopefully you have some strategy in mind regarding how to achieve the goal of your session. Will you make an emotional appeal by telling a moving and inspiring story of someone else's success? Or make an indirect threat as to what terrible things will likely happen if they continue on in the same way? An appeal to logic? A promise of great personal rewards for changing?

Whatever strategy you decide on determines the kinds of suggestions you will use to address the therapeutic theme. Direct suggestions to "stop doing that and start doing this" (e.g., telling a smoker, "Whenever you feel the urge to smoke you can go outside and slowly and deliberately take in some deep breaths of cool, clean air … and you can enjoy the good feelings of knowing you're gradually making yourself healthier … something you can feel especially proud of yourself for having the focus to accomplish") are probably the most commonly used approaches. Indirect suggestions, most commonly through the use of storytelling, are also used quite commonly used to suggest new ways of thinking about and responding to old problems, as in the following example:

> … When the townspeople started suffering strange symptoms, they finally realized the damage the smokestacks of the factory were doing to them and their families … and even though it was hard for them because the factory employed so many of them … they realized they had to shut the factory down so they could start breathing in clean air again … and get their health back … because what good is a job if you're sick … or if the people you care about are sick? …

The suggestions you employ in addressing the therapeutic theme are meant to associate some new responses to the problem context. Your suggestions may also be used to give clients a preview of homework you may be assigning later. You can do this by orienting them to the idea of what can be learned through experience, a process commonly known as *seeding*, and later assigning that experience as homework (Geary, 1994; Zeig, 1990).

Interaction Regarding Derived Meanings

This is a "check-in with clients to find out what's going on" phase of the hypnosis session. No matter how direct or indirect your suggestions might

be, regardless of however clear or relevant you think your suggestions are to clients, communication is a two-way street. Whatever the intention of your message, what your clients actually receive may be quite different. As you've learned, meaning is not in the words you use; rather, meaning is in the person who relates to your words in inevitably idiosyncratic ways. Thus, you can give someone a direct suggestion to go take a walk outside when she feels herself getting stressed, and all she heard was a dismissive "Take a hike!" Or you can tell someone a great story about another client with a similar problem, and all he hears is that you talk about your clients in your examples. Then he gets wrapped up in anxiously wondering whether you'll be using him as an example and thus never hears whatever the point of your story is.

Instead of talking at clients, and hoping they absorb some intended message, at this stage of the session you have offered suggestions of one type or another to help them and now you need some feedback as to what, if anything, they received from your input. The easiest way to do this is to simply say to them, "In just a moment I'm going to ask you to describe what you're aware of right now, perhaps in terms of what's different in your (understanding, body, perception, feelings), and you can describe to me quite easily what you're aware of." Did you notice the therapeutic presupposition in that suggestion? Clients can then verbalize what, if anything, is different, and you now have the opportunity to reinforce it if it's useful or contradict it if it isn't. But only by checking in with clients during the session can you have any sense as to whether they are deriving anything useful from your session and thereby have the chance to make midstream corrections to your approach if necessary.

Introduce Therapeutic Themes 2, 3, and so on

How many topics or themes can you address in a single hypnosis session? It depends on the client. Specifically, how much does it take for clients to feel appropriately stimulated, challenged, supported, unburdened, or enlightened, and how much does it take for them to feel overloaded? Some people will do best if you give them a single new concept to chew on, and others will be bored silly if you don't give them lots of new ideas to chew on. You have to assess their focus, level of stimulus need, level of distress, openness to the process, and other such variables that help you decide just how much to pack into a single session. However many themes you choose to address, you will obviously be providing suggestions and, hopefully, checking in with them each step of the way.

Provide Posthypnotic Suggestions (Contextualization)

By this stage in the session you have already introduced the ideas, perspectives, and methods that are meant to help your clients, and you've "checked in" and received some indication they have developed some new awareness

and sense of the beneficial possibilities. The challenge now is how to help them integrate these into their life. You may want to summarize key concepts, insights, or suggestions from other parts of the session at this point in the process as a precursor to linking them to ongoing life experience. Then, using the generic structure for posthypnotic suggestions you learned previously ("Later, when you're in situation X, you can do Y and Z"), you can offer fairly direct suggestions that build those links to the person's everyday life, as in the following example:

> The next time … and each time … you feel someone is trying to take advantage of you by imposing their wishes upon you … you can remind yourself that while other people may want what they want … which is quite natural … you now have a new choice … instead of just giving in to them … you can say yes or no to their demands depending on what you decide is best for you and best for the circumstances … and enjoy feeling stronger as a result.

Provide Closure

The session is now complete, and the process of facilitating closure begins. It is important to give clients the amount of time they need to process what has happened during the session. Some people process things very quickly and are ready to bring the session to an immediate end, and others are slower in assimilating new ideas and need some time to absorb it all. Most people, regardless of their rate of processing, simply enjoyed being so relaxed and comfortable and are in no hurry to end the session. So it is a good idea to first orient clients to the idea of closure by saying something such as, "You can review and absorb whatever important new possibilities you wish to as you prepare to bring this session to a comfortable and satisfying end," before suggesting actual closure. Then you can suggest they begin to bring themselves out of hypnosis at a comfortable rate: "And when you're ready, you can start the process of bringing yourself out of hypnosis at a rate that is gradual and comfortable." No one likes to be hurried out of hypnosis, and it can be quite disorienting, even uncomfortable, if clients are encouraged to come out of hypnosis too quickly. By letting them control the rate at which they reorient, you can avoid the mistake of hurrying clients who may likely become at least mildly resentful.

Suggest Disengagement

In this final step of the process, clients are encouraged to slowly reorient and open their eyes, perhaps by suggesting, "And when you're ready, you can fully reorient yourself, and let your eyes open whenever you'd like … fully reoriented, becoming fully alert … eyes opening." The first moments after

they have opened their eyes are particularly sensitive ones as they think about the session while "reconnecting" with you. Waiting silently until they feel like speaking is generally a good idea, although you can also quietly offer further suggestions consistent with your goals at this time, since they are still usually partially in hypnosis. Reorienting is a process, not an event.

DELIVERING INTERVENTIONS: SESSION FOLLOW-UP

When the hypnosis session has ended, the opportunity exists to do some debriefing with clients about the session. As with every other aspect of the treatment process, this requires some thoughtful planning. On one hand, detailed debriefing about the session by asking questions such as, "How was that for you?" or "What was your experience like?" can provide you with valuable feedback about how they responded and what they thought or felt that can be important feedback for helping shape future hypnosis sessions and even the overall direction of the treatment. On the other hand, some of the things that happen during hypnosis sessions, such as fantasy imagery that has no logical basis, such as revivifying adult clients' experience of being a carefree child, can create powerful emotional responses that are very helpful to the person to have yet would fall apart under conscious scrutiny. So you have to give some thought as to how much of the session you want to analyze before such analysis becomes detrimental to the session's results.

The next opportunity for follow-up is usually in the next session, although some clinicians will send email inquiries about afterthoughts about the session and even forms for clients to fill out evaluating each session. Generally, though, it is the next session when the clinician has the chance to find out what, if anything, is now different in their experience. Has anything changed? If so, what? Do they seem to have absorbed and made use of suggestions given during the hypnosis session? If so, are they aware of having done so, or does whatever is different seem "automatic," occurring outside of their awareness for expending deliberate effort?

The times hypnosis seems most mysterious and compelling are when clients have made changes in obvious response to the suggestions you have offered, yet they seem to have no awareness for the connection between what you suggested and what they are doing differently. Such results gives hypnosis that "magical" quality, which is fascinating but which may also be clinically undesirable: if we want to empower people, having them make changes without any sense of personal connection to those changes, commonly termed *agency*, simply reinforces a disempowering belief that these things happen to them instead of being caused by them. I'm a strong fan of taking the magic out of the process and replacing it with a sense of deliberateness on the part of clients, emphasizing that they did actively participate

in some way to make changes possible, even if they aren't aware of that yet. You can encourage greater agency by linking new behaviors with improved conditions, asking about and reinforcing "what you're doing that's different and working better."

What if clients come back for the next session and nothing seems different or, worse still, if things have actually gotten worse? There are many different possibilities as to why an intervention of any type, including hypnosis, can fall flat. Some of the possibilities have to do with clients (e.g., negative expectations, inadequate motivation, misapplying suggested concepts, lack of willingness to experiment with new possibilities), some have to do with the clinician (perhaps being too emotionally threatening, too controlling, or too condescending), and some have to do with the interaction between the two (as in inadequate rapport or having conflicting goals). Debriefing clients under these circumstances becomes even more important for the clinician. Did they listen to the recording of the session again? (I record my hypnosis sessions routinely and provide them to clients as a structured means of reinforcing our work and have found this an enormously useful strategy.) If so, what did and didn't fit for them? If something didn't fit, why?

I want to know what I can do differently in subsequent sessions to be more helpful. Even when it's clearly that their issues are getting in the way, I have to be able to address those limitations and try to resolve them as part of the process of therapy. But it means backing up a step or two to address those issues before going on in a different way. If it's my approach that needs adjusting, I'll do my best to adjust it. If it's the quality of our interaction, I'll do what I can to change what I do there, too. The important point is that feedback allows for the possibility of change, wherever in the process a change may be indicated. It may be easier to simply blame clients for their lack of progress, of course, but as you can tell, I'm not inclined to blame them for what they don't know how to do. I'd rather strive to create a context where they can explore the possibilities and learn to choose wisely.

THE ART OF DESIGNING AND DELIVERING CLINICAL HYPNOSIS SESSIONS

Conducting good clinical interviews that yield significant information and insight into the structure of individuals' problems is an art. Establishing rapport and a good therapeutic alliance with clients is a form of social artistry. Adapting your style and demeanor to clients, since what it takes to impress a young child you're going to treat is quite different from what it takes to impress an adult, for example, is artistry in behavioral flexibility. Designing a session to acknowledge and incorporate clients' unique attributes while simultaneously

keeping an eye on the goal is organizational artistry. Communicating an expectation of success and encouraging clients to discover new possibilities is an art of building a growth-oriented therapeutic context.

In this chapter, many of the nuts and bolts of clinical intervention involving hypnosis have been assembled into a general framework for evolving the art of performing clinical hypnosis. No book, no person, no scientific study can tell you exactly what to say or when and how to say it best to a particular client. The only person that can give you the salient feedback about "what works" is your client. And what works for one individual may be quite different from what works for another. Perhaps ironically, therefore, hypnosis, a highly directive approach for its strong goal orientation, is also among the most respectful and client-centered of approaches.

FOR DISCUSSION

1. Who do you think of as "being hypnotic" and why? Does the person intend to be hypnotic, or is it simply something about the way he or she is as a person?
2. What does it mean to have your clinical training be a veneer that overlays who you are as a person? What specifically do you bring to the therapy context that is uniquely you?
3. Do you make a distinction between a wish and a goal? How would you distinguish them for a confused client?
4. How is your style of therapy a reflection of you at least as much as the way you see problems you hope to solve?

THINGS TO DO

1. With the emphasis on therapy being more empirically based, it will be important to keep current with research in your area. Pick a particular symptom you encounter and read some of the latest journal findings on what the treatment data suggest it takes to address it effectively. Then develop a set of hypnotic suggestions for resolving it.
2. Write out briefly three events in your life that were somehow significant to you. List your personal resources that led you to respond as you did.
3. Make a list of common symptoms. If a client presented you with several of them, which would you focus on first and why? Ask others and compare your answers.

CHAPTER 21

CLINICAL HYPNOSIS IN PSYCHOTHERAPY

Throughout this book there have been numerous descriptions of ways to apply hypnosis in a variety of clinical contexts. Hypnosis is especially widely used in the context of psychotherapy as a vehicle for helping people on a variety of levels, from empowering them to be better problem solvers to teaching better coping skills to building better, more satisfying lives. Hypnosis is unapologetically goal oriented in nature, for each time individuals do hypnosis the clinician has a specific outcome in mind. The clients establish the goals, of course, and the clinician strives to create a context through hypnosis that makes it possible for clients to develop the necessary skills to reach those goals. It bears repeating that hypnosis in and of itself cures nothing; rather it's what happens during hypnosis that has great potential to be therapeutic. Thus, in this chapter, I describe a few specific strategies commonly employed during hypnosis and how they may be utilized for addressing a few of the most common problems clients present in psychotherapy.

REPETITIVE PROBLEM THEMES

The goals for each session and the steps toward achieving those goals will naturally vary with each client, but specific problem themes frequently recur in psychotherapy across many clients. Some examples of these repetitive problem themes are (1) encouraging people to take responsibility for themselves; (2) encouraging people to be proactive on their own behalf; (3) helping people develop greater self-awareness and self-acceptance; (4) helping people develop and maintain a clear sense of their personal boundaries; (5) helping people make good decisions with insight and foresight; and (6) helping

Table 21.1
Assumptions Inherent in Hypnotic Psychotherapy

Influence is inevitable; all therapy is directive to some degree.
The clinician is a catalyst for change.
The client wants change to occur.
The problem is in the client's perceptions, not the client.
The client has utilizable resources for change.
No one is completely helpless.
Each person is making the best choice available.
Choice is better than no perceived choice.

people adjust to difficult circumstances. There are, of course, many, many other recurring themes as well.

These problem themes surface regularly in the course of psychotherapy, and it is to the clinician's advantage to recognize them in whatever form they may appear. The specific way that one person expresses feelings of helplessness, for example, might be quite different from the way another person expresses them. Yet the astute clinician will see past the differing content of the presentations and recognize the need to address the themes of taking responsibility for becoming proactive in making and implementing good decisions that improve things. Having a variety of hypnotic strategies available in one's repertoire for addressing and facilitating some meaningful resolution of these recurrent themes is invaluable. The assumptions associated with the use of hypnosis in psychotherapy are presented in Table 21.1 as a way of orienting you to this chapter's subject matter.

SYMPTOM STRUCTURES AND HYPNOTIC PHENOMENA

I previously described hypnotic phenomena as the building blocks of subjective experience, whether organized for good or bad outcomes (Araoz, 1995). Developing the ability to view everyday experiences in terms of the associated hypnotic phenomena can help you develop the ability to more easily identify the structures of experiences (i.e., how the problem pattern is organized), not just their content (i.e., what the symptoms are).

In the context of conducting therapy, identifying the hypnotic phenomena associated with clients' symptoms permits you a more rapid and comprehensive understanding of the problem. Knowing the sequential steps involved in the creation of the symptoms permits you the opportunity to choose at what point in the symptomatic sequence you may introduce an intervention that alters it in some beneficial way.

Visualization and a Fear of Flying

Consider the example of someone who has a fear of flying. How does someone generate such a fear? What is the symptom-producing internal sequence? Despite individual variations, there is a general sequence most airplane phobics follow. They anticipate they will be anxious even weeks before the flight; once actually on the plane, they visualize in great detail the airplane they're sitting in taking off, and soon after this imagined takeoff, they visualize the engines falling off or flaming out. Then they visualize with horror the plane going down and crashing at top speed, and then they see detailed images of twisted metal and body parts scattered all over the hillside. The last step of this absorbing sequence is an awareness of feelings of sheer terror. Visualization, a type of self-hypnosis, can be a great therapeutic tool. In this context, however, it is being applied to generate symptoms of intense anxiety around flying. Visualization, imagery, self-hypnosis, and hypnosis are neutral, capable of generating both therapeutic and symptomatic experiences.

Imagining yourself on an airplane that is imminently going to crash and kill you is a horrific sequence of images. With such disturbing imagery, it is easy to appreciate how a fear of flying is generated (Wilson, 2009). Asking why someone would visualize this sequence of events is unnecessary; the flight attendants begin every flight with instructions of what to do if the plane loses cabin pressure or power and what to do in the event of a "water landing." Everyone thinks of the potential for a plane crash simply because as a passenger you are required to. But even though everyone hears the safety information and understands the potential for a crash, most people aren't phobic. Why not?

There are many different ways of treating such individuals, from deeper symbol-laden interventions analyzing the psyche to more direct cognitive-behavioral strategies. Hypnosis can be integrated with any and all of them, suggesting alternative images and ways of thinking about flying. Even the most superficial hypnosis approach would at least offer suggestions to think about flying comfortably, seeing detailed images of the wonderful things to be experienced at the destination and framing flying as a liberating experience that can enlarge your world. In essence, the clinician is saying, "Here, visualize these relaxing images instead of those terrible images." While the content of the visual imagery changes in such an intervention, both the solution and the problem are comprised of images of the future (i.e., elements of age progression) that feel immediate and real in the present.

The people who fly comfortably do something quite different with the safety information. They acknowledge the possibility of a crash but immediately dissociate from it, considering it only a remote possibility. By distancing themselves from the possibility, for example by thinking, "Yeah, I suppose this plane could crash … and I suppose I could be crowned King of America, too," the threat is minimized. For the phobic, the strategy is the opposite by maximizing the threat and interpreting every bump or sound as evidence a crash is imminent.

Table 21.2
Symptom Phenomena as Hypnotic Phenomena

1. Identify hypnotic phenomena evident in symptomatic patterns, for example:
   Overweight: physical dissociation, sensory alteration
   Smoking: physical dissociation, sensory alteration
   Depression: age regression, catalepsy, sensory alteration
   Anxiety: age progression, time distortion, sensory alteration
2. Use complementary hypnotic phenomena in interventions
3. Contextualize responses through experiential approaches, such as task assignments and behavioral prescriptions

In the same way that age progression in the generic form of becoming experientially absorbed in a fear of bad things that might happen in the future is generally evident in anxiety disorders, it is possible to similarly characterize other problems according to associated hypnotic phenomena. Table 21.2 provides some relevant principles and examples.

Dissociation and Cigarette Smoking

Consider the average smoker from the perspective of how hypnotic phenomena are evident in the pattern of smoking. Smoking is a terribly self-damaging habit, yet despite the warning labels and the laws passed to discourage smoking more than 50 million Americans continue to smoke. Most of them began smoking as teens to be "cool," and the habit just generalized across situations. This is not a deep "cause" necessarily needing to be analyzed. Despite getting sick the first few times, they endured the nausea and eventually overcame it and gradually became dependent on cigarettes.

For individuals to smoke, what must they do to make it possible to inhale foul-tasting smoke and gas containing hundreds of deadly toxins and even proclaim to enjoy it? They must learn to detach—*dissociate*—from the negative effects of smoking. That's why smokers are typically unaware of the immediate stress and damage to their body with each and every puff of the cigarette. They typically do not feel their heart rate and blood pressure increase as their body fights for oxygen, nor do they feel the carcinogens circulating throughout their body. They don't smell the foul odor of tobacco on their clothes, hair, breath, or surroundings (car, home, office) and, generally speaking, tend to be quite oblivious to the many sensory and physical effects of their smoking.

Do you know when many people decide to quit smoking? When the elevator at work breaks. Taking the stairs highlights very quickly their degree of physical (un)fitness. Typical smokers don't try to quit until there is some situation where the negative effects of their smoking is dramatically brought into their awareness—an *associative* experience.

The main idea in identifying hypnotic phenomena underlying symptom phenomena is that it provides you with some understanding of the kind of experience you want to encourage hypnotically. As a general principle, therapy takes the form of providing complementary experiences, helping people develop either undeveloped or underdeveloped personal resources. In smoking, for example, *dissociation* is a large part of the problem. Thus, *association*, the complement to dissociation, is going to be a large part of the solution. Building associational cues (triggers) to encourage an increased body and sensory awareness is a likely path to the successful treatment of smokers (Zarren & Eimer, 2001; Zeig, 1980). Tying cues for better health and the redefinition of yourself as a nonsmoker to the specific contexts through the use of posthypnotic suggestions is an important step of the treatment. For excellent reviews of the use of hypnosis in helping smokers, see Green (2010) and Lynn and Kirsch (2006).

Notice how the intervention described here for smokers is not based on an interpretation of the "meaning" of the smoking. Interpreting smoking as a suicidal wish, a socially defiant behavior, an oral gratification representing a fixation at the oral stage of psychosexual development, or any other such assignment of meaning is both arbitrary and unprovable. What is clear, however, is that smokers are dissociated, for whatever reason, and they need to build new healthy associations to their body as well as develop the other resources necessary to move forward in life without cigarettes.

The dissociative aspect of people's symptoms is an especially noteworthy point to appreciate. Clients routinely describe how the symptom "just happens," meaning it is not a voluntary response on their part. I generally define therapy as a process involving *pattern interruption* (i.e., getting the person to stop doing one thing) and *pattern building* (i.e., getting the person to do something else), as virtually all therapies must do. New associations can best be built through direct experience, such as hypnotic processes or structured learning opportunities such as role plays, homework assignments, and behavioral experiments.

The key points, then, of this section are twofold: (1) utilizing hypnotic phenomena as a reference point can be a useful means for understanding symptom structures; and (2) solutions can take the form of building new associations through the use of complementary hypnotic phenomena.

As was done in the examples listed in Table 21.2, it may be useful for you to identify which hypnotic phenomena are evident in the types of disorders you tend to treat most frequently.

PATTERNS OF HYPNOTIC INTERVENTION

Applications of clinical hypnosis are as diverse and creative as the number of clinicians working with it. There is no human problem that can be solved in

all people through a one-size-fits-all formula. Giving simple and direct suggestions to your hypnotized clients for what to do to solve a problem is one possible form of intervention since such an approach can work with some people. But the patterns described briefly in this section are based on the recognition that most people need something a little more multidimensional than only direct suggestions of symptom abatement.

Individualizing treatment is always a necessity, in my opinion, and that means tailoring general patterns of intervention to clients' specific needs. Patterns range from relatively simple and obvious to very complex and subtle. The following are some of the more common hypnotically based patterns for intervening in client problems. More complex and specialized approaches are readily available in the clinical literature contained in the references at the back of this book. The patterns described here are listed in alphabetical order for easier reference.

Accessing and Contextualizing Resources

Perhaps my favorite strategy because it is so positive and empowering, the process of hypnotically accessing and contextualizing resources brings to life the belief that people have more strengths and resources than they realize, particularly when they are preoccupied with feeling symptomatic and powerless, the antithesis of feeling resourceful. It is positive psychology in action.

The essence of the strategy is to delve into individuals' history, find examples of having used resources well that are the very resources that would be helpful to counter the problem situation (the phase of accessing resources), and then crystallize those resources and extend them into the problem situation as better ways of managing it (the phase of contextualizing resources). Age regression is used to recall or revivify some meaningful episode from the past, resources are identified and named such as courage, creativity, or perseverance, and then age progression is utilized to integrate those resources into some trouble spot in such a way that those resources would lead to new helpful perspectives, reactions, and behaviors. When people reconnect with their own resources, inarguably present in their history, it is often moving and transformative for them. (This strategy is described in greater detail with a session transcript in Yapko, 1992.)

Changing Personal History

The pattern called "Changing Personal History" has been used routinely in clinical intervention in a variety of forms and with a variety of names. As you can gather from its name, the purpose of the hypnotic intervention is to help people redefine their view of their own personal history. So often in treatment, people have come to see themselves as victims of the past, permanently

damaged and unchangeable. This strategy is appropriate to use with such clients, particularly when they are presenting a problem that has its origins in a hurtful episode where they made some negative life decision that perpetuates their distress (Phillips, 1988). For example, if clients had the experience of being physically abused as a child and made the decision (i.e., formed the generalization) that the world is an abusive place and people are never to be trusted, the clinician might age regress them to their earliest memories and suggest the hurtful decision be "redecided" to facilitate the (imaginary) experience for them of feeling loved, cared for, and protected by others. The resources of affection and caring can be provided through imagined but realistic suggested interactions, such as their mother expressing love and approval when they bring home a good report card or just offering spontaneous hugs and affection. Clients are then guided forward through time while having a subjective sense of love and caring present across all their life experiences. In doing so, their feelings about themselves and others can change in a healthier direction.

Here's a case example illustrating the pattern. In the case of a man I worked with whose mother had died when he was a boy of 7, he had "decided" (not consciously) that "women were not to be trusted and gotten close to because they leave you." Through age regression to the time of his mother's death, he remembered feeling abandoned, angry, and hurt, and he decided then that the best way to prevent such emotional pain was to never get close to anyone, especially women. His life, as you can imagine, was lonely and painful.

The strategy of changing personal history was used with him. When he was age regressed to his fondest memories of his mother, times when he felt her closeness and love, it was possible to make those good feelings of having her around more readily available to him for recall when he wanted them. This was done through building an "anchor," or association, to those good feelings; specifically, he could vividly "see" her and "hear" her voice respond to him in his thoughts whenever I touched his arm. The next step was to suggest a temporary amnesia during the session for the reality of his mother's death. Once this was established, we could examine his life experiences, both good and bad, and have him "recall" sharing them with his mother as if she had really been there. In hypnosis, she could grow older with him and be there for him in the way he had needed her. The experience of having his mother "with him" in a variety of very specific life situations through the years, such as preparing for his first job, getting his driver's license and pleading to use the family car, and graduating from high school, allowed him to redefine his view of her and his relationship with her. Suddenly, his mother hadn't abandoned him and women weren't so unreliable. It served to alter his feelings and behavior toward women, especially when he had the insight that "dying obviously wasn't her idea, anyway."

In helping "change" his (perceptions of) personal history through hypnosis, I simply provided a means to experience many of his important life experiences with the "missing piece," namely, his mother. This felt sense of having

her there instead of a gaping hole where she should have been allowed him to gradually feel, hear, and see life from a different, healthier, and happier perspective. Did he know the life experiences generated in hypnosis with his mother were imaginary? Yes, of course he did. Were they emotionally powerful anyway? Yes, they were. It is the power of hypnosis to help people get absorbed in experiences that are not objectively "real" that makes therapeutic interventions with hypnosis potentially so therapeutic. Recall the earlier discussions of trance logic and "believed-in imagination." (This strategy is described in greater detail with a session transcript in Yapko, 1992.) Phillips (2004) described a variation of this strategy in what she termed *renurturing* protocols, ways of changing history to hypnotically include nurturing figures to replace lost or absent ones in clients' history.

Critical (Traumatic) Incident Process

People can't go through life without experiencing trauma of one sort or another. Cars crash, people die, wars are fought, and people seem to regularly evolve new and innovative ways of hurting each other. In addition to these harsh realities, everyday traumas can often have a serious impact: the mean kid in class who bullied you relentlessly, the practical joke someone played at your expense that left you standing there wanting to die of embarrassment, and the thoughtless and cruel comment made in public by a loved one about something you can't do a thing about are all examples of the everyday trauma that can have a profound impact on your life. Years later such traumas may even seem silly and irrational on a logical level yet can still carry a big emotional wallop. In persons who have suffered a trauma of some sort, the traumatic event may well have been a turning point in their life. In such cases, then the hypnotic critical incident process may be an appropriate treatment strategy (Baker & Nash, 2008; Erickson & Kubie, 1941/1980; Spiegel, 2010).

This is an emotionally powerful hypnotic process, intending at its initial stages to release pent-up emotions associated with a traumatic event ("catharsis"). If clients have full conscious memory for the content of the critical incident, you may simply proceed in a relatively straightforward way. However, if the traumatic incident seems to have been responded to with elements of dissociation and amnesia, which is common, the process is more hazardous and needs to be handled with great care. Advanced training in trauma resolution techniques is highly recommended before you attempt to work in this sensitive area.

When conducting a critical incident process it's important to let clients work at their own rate and not push them to deal with something directly they feel unable to. Ideomotor questioning, the use of finger signals to provide yes or no responses to your questions about readiness, may help you assess whether they are ready, willing, and able to deal with the traumatic experience or the consequences in their life.

Table 21.3 provides a general structure of the critical incident process.

Table 21.3
General Structure of a Critical Incident Process

Induction, establish anchor to comfort
Age regression to context
Exploration of context
Elicit affective associations
Identify central distortions
Catharsis
Dissociation of affect
Dimensional shifting of representation/reframing
Restructuring of focus and memory content
Amplification of alternate representations
Age progression with new resource
Posthypnotic suggestion for future accessing
Reorientation

The critical incident process involves age regression back to the time of the traumatic experience. Generally, it is a good idea to first do a regression to a positive experience, demonstrating to clients that they can trust the clinician's guidance, find comfort or something positive within themselves, and maintain control of the hypnosis experience. You can then facilitate either hypermnesia or revivification, depending on the appropriate level of emotional intensity needed to rework the situation. Revivification is more emotionally intense than hypermnesia, and without the safeguards in place of an "escape hatch" of some sort, such as a safe place inside to go to or a finger signal that indicates the need to step away from the experience, it can be too intense for the person and thereby retraumatize them. It bears repeating that therapy can be harmful despite one's good intentions.

Once clients have become immersed in the memory of the experience, describing it aloud so the clinician can know what's happening and how they interpreting the meaning of what's happening, the clinician's primary role is to offer them support for exploring the episode. Simultaneously, the therapist can identify and amplify some part of the episode clients had previously not attended to, such as how insecure (angry, sick, hurt …) the other person involved might have been or how bravely they coped in the face of adversity or some such thing that can be used as a pivot point to start to redefine the way the traumatic episode is stored and remembered (Lankton, 2001). Additionally, one might strive to change the history of the situation by adding something new to the interaction to make it easier to bear, such as successfully fighting off the attacker this time.

By supporting the expression of emotional pain, the clinician can usually guide clients to a point where they can start to feel differently about the

situation. Frequently, just having the chance to tell the terrible story that has never been told and release some pent-up emotion in a supportive atmosphere has ample therapeutic value (Phillips, 2001; Phillips & Frederick, 1995). But the strongest part of this process is in guiding clients into developing a new awareness or new understanding of the meaning of the experience, redefining its place in their life in an empowering way. To complete the process, clients can be age progressed, integrating into the future the changes in thoughts and feelings associated with the release of the hurt, bringing with them new conclusions about both the critical incident and themselves.

The same process can always be used to revivify an experience that was critical in clients' lives in a positive way. This can be an especially powerful means of helping people get and stay connected to the best parts of themselves. Typically, though, the experiences that wreak the biggest emotional havoc on people that catapult them into treatment are traumatic ones, requiring a great deal of sensitivity on the part of the clinician. It is vital to be judicious in one's use of trauma-focused therapies. Many clinicians I am aware of are "emotional voyeurs" who want or need to help their clients "get in touch with the pain." Some even openly call themselves practitioners of "abreactive therapy." The reality is that if you look for people's pain, you will always find it. However, that isn't necessarily therapeutic and may actually be antitherapeutic by amplifying hurt needlessly. Caution is advised.

Seeding Homework Assignments

In a recent review of the literature on homework and psychotherapy, researchers concluded that, across treatment modalities, therapists who give their clients homework assignments and who facilitate client cooperation with homework are likely to observe better treatment outcomes (Detweiler-Bedell & Whisman, 2005). Prescribed properly, a good homework assignment will usually address unconscious dynamics of the presenting problems. When clients actively engage in an activity that will cause them to experience themselves differently while confronting self-limiting thoughts, feelings, and behaviors, new associations are formed and the desired change may be accomplished (Haley, 1973; Lankton & Lankton, 1983, 1989).

Most clinicians claim to regularly make use of "homework," educational tasks clients are given to carry out in between therapy sessions (Cummings & Cummings, 2000). These are intended to encourage new behaviors and the development of new skills, to test out the accuracy of one's perceptions, and to amplify particular thoughts, feelings, and behaviors that the clinician judges important to the therapy. Homework assignments operate on the level of actual direct experience, a more powerful level than the merely intellectual. Homework helps people integrate new learnings on multiple levels. And by assigning homework clients have to expend effort, increasing the likelihood that they will value the therapy more (Lynn & Sherman, 2000).

The homework assignment isn't necessarily hypnosis, but it is certainly hypnotic in its potential to absorb people in new frames of mind and develop deeper understandings of themselves and their life circumstances. Homework can be done in hypnosis, however, when carried out in the "waking" state as in an "active-alert" hypnosis framework (Capafons & Mendoza, 2010; Wark, 2006). Homework can also be thought of as an *experiential metaphor* in the treatment process, a parallel to clients' problems that are embedded in an activity rather than a story.

Preparing clients to do homework is an effective use of hypnosis. This is a process called *seeding*, described by Jay Haley (1973) as establishing certain ideas and later building upon them. Jeffrey Zeig (1990) defined seeding as "activating an intended target by presenting an earlier hint" (p. 222). During the course of the hypnosis session, addressing therapeutic themes and presenting suggestions for experiential possibilities, the clinician can allude to places people might go to observe or learn something valuable and then, after the hypnosis session is completed, present an assignment to actually do and experience what was alluded to during hypnosis.

In one case example involving assigned homework while working with a depressed client, at one point in the therapy I wanted to target this woman's depressing patterns of making negative comparisons between herself and others. She assumed and really believed that "everyone else is happy and I'm not," "Everyone else has fun and I don't," "Everyone else's life is easy and mine's hard," and on and on. She virtually never strayed outside her immediate comfort zone to go anywhere interesting or try anything new, and it's fair to say she was exceptionally dull. Simply telling her, "You know, you assume way too much about things at the expense of actually checking out whether things are as you think they are," is an intervention that will likely fall flat. She believes herself too easily. So, to make the point more experientially, I instructed her to go to a nearby state park and hike a trail there called the Azalea Glen Springs Trail. Sounds beautiful, doesn't it? Can you picture the fields of beautiful azaleas? Can you imagine the clear mountain springs spilling over the rocky terrain? Well, don't. There are probably four azaleas you see on the hike, and the "spring" is little more than a metal pipe dripping water out of the side of a hill. This particular client, as part of her depressed mental set, built things up way beyond what they really are in a way that always put her at the bottom. In instructing her to hike the trail, I knew she'd imagine flower fields and the springs as abundant, beautiful, and flowing with water. I also knew she'd be in for a big surprise when she got there after several miles of moderately difficult hiking and found such an unexpected and underwhelming sight. And I knew that for someone who hardly ever leaves her living room, the experience would be dramatic. It was.

When I saw her the day after her hike, she was by far the most animated she'd been since I'd met her. At the start of the hike, she was annoyed with me for telling her to go, and she was annoyed with herself for agreeing to

go. She couldn't understand what she could learn on a trail that she couldn't learn more directly and easily in my office. But she stuck with it, to her credit. When she finally arrived at the Azalea Glen Springs, filled with expectations, and found only a small pipe dripping water out of a mound of dirt labeled the springs, at first she was confused. But then she found it very, very funny that after all her hiking and high level of expectation all she found was a dripping pipe coming out of the ground. During her return hike she thought very hard about why I would ask her to hike such a disappointing trail. After a while she had the realization that she had set herself up for disappointment by building the springs up into something special in her mind when, in reality, the springs weren't at all the way she had imagined them. She broadened her thinking and had the "big aha!"—that she is almost always building things up to be better than they really are and making herself worse than she really is. On the spot, she decided to make greater effort to find out the true value of things from her own direct experience rather than from assumptions rooted in her insecurity.

This homework assignment provided her a much more intense experience of herself than would my saying to her in or out of hypnosis, "You build things up in your mind to be better than they really are and you make yourself out to be worse than you really are, so stop doing that." The hike served a number of therapeutic purposes: it symbolically matched her "going uphill against the world" feelings; it got her physically active, a great tool in dissipating depression; it caused her to confront her unconscious pattern of maximizing everything and everyone else while minimizing herself; and it boosted her self-esteem by giving her a greater feeling of being in control of herself, for she had accomplished something meaningful all by herself.

Assigning homework or task assignments that will address clients' concerns can take a variety of forms. In addition to the previously described symbolic task, another type of assignment can involve clients "making the symptom inconvenient." Typically, a symptom is coddled and catered to, for clients adapt their life to its presence. Having clients do something that will make the symptom exceptionally inconvenient can effect a surprisingly rapid and lasting change. It can mobilize resistance against the symptoms themselves (Haley, 1973, 1984).

Homework assignments involve more dimensions of the person in the therapy than does verbal dialogue alone. It also allows the interventions to generalize to times and places outside the clinician's office, allowing changes to be more easily integrated into clients' lives. Homework assignments can make a point on a variety of levels simultaneously, both directly and indirectly, and when used skillfully are an art form in their own right.

Reframing

The meaning of an event or a communication is determined to a large extent by the context in which it appears (Watzlawick, Weakland, & Fisch, 1974). For example, a single word such as *no* can actually mean a wide variety of things

ranging from a firm, clear "No" to a wishy-washy "I don't know" to an affirmative "I guess so," depending on people's tone of voice, body posture dynamics, and the social context. When the same action or event can be interpreted in a number of plausible ways, helping clients let go of an interpretation that hurts to accept one that helps is the process of reframing. Watzlawick et al. defined reframing this way: Reframing is "to change the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame which fits the 'facts' of the same concrete situation equally well or even better, and thereby changes its entire meaning" (p. 95).

Changing the context of a communication changes its meaning and value. A behavior may be perfectly acceptable in one situation but not in another. Consider the act of stealing as an example. Stealing money from a blind beggar is an act no one would condone. Stealing a serum that will cure your mother's terminal cancer from a greedy neighbor chemist who discovered a cure but wants a million dollars you don't have and can't get to buy that cure is the same act of stealing. Yet it stimulates empathy in most people rather than anger and a desire to punish the offender. Lying by the government to the public is considered a betrayal, unless it's for "national security." A man who acts strangely is "crazy" if he's poor but "eccentric" if he's wealthy.

The various euphemisms that abound in the English language are all simple and effective *reframings*. With the turn of a phrase, especially during hypnosis, liabilities are turned into assets, traumatic events are converted into learning experiences, weaknesses are turned into strengths, and so forth. Reframing can be accomplished with a single remark or can involve a lengthier, more experientially absorbing hypnotic experience. Any approach that encourages clients to have a different perspective on the problem involves a reframe. As soon as you say, "Look at it this way …," you're attempting a reframe.

The clinical skill involved in reframing is to suspend clients' self-limiting belief system long enough for them to consider an alternate viewpoint. Turning the "half-empty" glass into a "half-full" one is an obvious example of how a negative viewpoint can be transformed into a positive one. Reframing can work in the other direction, too. An action clients engaged in that they felt fine about until the clinician said, "How could you let yourself do that?" could rapidly turn their comfort into distress. Most interventions, though, are intended to transform pain into comfort.

An underlying assumption in doing reframing as an intervention strategy is that every thought, feeling, or behavior has some positive value somewhere but not everywhere. By taking an experience that clients view as negative and commenting on how and why that same experience might actually be an asset to them somewhere else, the clinician can change their attitude about that experience, particularly when suggestions for new and better alternatives are offered as well for replacing what wasn't working.

As another example, a woman complained that her husband's habit of snoring was disturbing her sleep. She was told an emotionally charged story by a

recently widowed friend she happened to complain to. The widow described her loneliness since her husband died, how much she felt the weight of her husband's death on her every experience, and how much she longed to hear her deceased husband's snoring, something she said she'd hated about him when he was alive. The impact on the woman complaining about her husband's snoring was to instantly develop an appreciation for her husband's snoring, because it was clear, reassuring evidence he was still alive and well. It actually became comforting to her. Her husband's snoring behavior was the same; only her attitude about it was changed. That's a successful reframe.

Finding a way to turn a minus into a plus, or vice versa, if appropriate, is a basic part of clinical work. Learning and using the techniques of reframing, especially during hypnosis when people tend to be more flexible and responsive to suggestions and implications, can make the transformation of clients' personal reality a smoother, more efficient process.

Therapeutic Metaphors

Stories as teaching tools have been the principal means of educating and socializing people throughout human history. Metaphor, in the world of hypnosis, has generally come to mean the use of stories in the treatment process. The use of therapeutic metaphor is a core component of most modern hypnotic processes, a lasting tribute to the influence of Milton Erickson on the field of hypnosis. His use of folksy teaching tales with his patients was a great innovation at a time when other hypnosis practitioners were uniformly direct and authoritarian in their methods. Studying Erickson's work and discovering the value of stories as a means of communicating ideas powerfully and memorably led to an explosion of books and articles on the subject. Building and telling stories as a vehicle for imparting therapeutic messages is a complex and powerful therapeutic skill to develop (Erickson, 2001; Haley, 1973; Lankton, 2008; Rosen, 1982).

Therapeutic metaphors can be created in such a way as to parallel clients' problems and may be told in such a way as to absorb them in the metaphor. As Australian psychologist George Burns points out in his excellent series of books regarding metaphors (2001, 2005, 2007), beyond getting the clinician's intended point of the story, clients may project meanings into the story that the clinician didn't even intend to communicate. These may have even greater impact than the intended meanings.

The best metaphors are usually those found in clients' direct experience. Naturally, these are more personal, more immediate, and easier for them to relate to in a meaningful way. If you take the time to review episodes in clients' lives that had special significance, perhaps because they taught them something valuable about life, you can have immediate access to a wealth of potentially meaningful metaphors. Likewise, your own background and personal history reflect important learning experiences, and these may be used as

the basis for therapeutic metaphors as well. The more you participate in life, the more experiences you have to draw upon when constructing therapeutic metaphors. Cases you have worked on or read about that illustrate worthwhile points are also a good source of metaphors. Other sources include storybooks, movies, jokes, anecdotes that illustrate important points about human nature, newspaper stories, television programs, and virtually any other milieu from which you have the opportunity to learn important lessons about living life well by considering other people's experience.

Learning to tell stories in a hypnotic, engaging manner is a vital skill to develop for doing hypnosis well. The metaphor has to be introduced in some way that invites people to engage with and learn from it, a technique called *framing the metaphor*. So one might say, "I'm going to tell you a story that at first you might wonder why I'm telling it to you … but as you pay closer attention and become absorbed in the story … I think you'll discover something valuable that can be of help to you.…" How close or distant the metaphor should parallel clients' issues is a matter of clinical judgment, as is how many stories on a theme to tell and which elements of the story you most want to emphasize.

Metaphor is obviously an indirect way of suggesting possibilities to clients. Instead of saying, "Do this," you say, in essence, "Once I had a client who faced a problem similar to yours, and one day he tried this and it helped." Clients can be encouraged to learn from others' experiences, whether to apply a specific suggested solution or, more generally, to simply be willing to experiment with new possibilities. Clients are encouraged to conduct a "search for relevance," actively engaging with the story and exploring its salience. The use of metaphor isn't a heavy-handed approach. To the contrary, it is a respectful way of suggesting possibilities without demanding much from clients. A common consequence of this approach is that change can sometimes seem relatively effortless, as if it "just happened," a possibility that the clinician can allow for.

The necessity of always formally inducing hypnosis diminishes as, on occasion, you provide a compelling story, told hypnotically, without the formality of an induction. The induction occurs indirectly as clients become absorbed in the telling of the story. Clients' natural ability to drift in and out of hypnosis as they listen to the clinician can be tapped and amplified by the clinician wanting to use a metaphorical approach (Brown, 1993).

Without offering magical interpretations about the all-knowing wisdom of the unconscious, I can simply say metaphor has a way of stimulating clients' internal associations and directing them toward problem solving in a way that not only makes sense but also works. And, to be sure, some changes do take place rather "spontaneously," with no apparent internal tug-of-war. For an example out of your own life, consider those foods you hated as a child that you now truly enjoy. These are probably not foods you forced yourself to learn to like. Your tastes changed, they evolved—and they changed relatively effortlessly.

Obviously, not all or even most changes take place so effortlessly, making the process of therapy uneven in both practice and rate of success. But the therapeutic metaphor as a means of imparting valuable messages in a memorable context (i.e., the drama of the storyline) stands a very good chance of facilitating such seemingly spontaneous changes. Spend a day or two just noticing the things that happen in life that illustrate principles of effective living; practice telling people about those events while leading them to discover the principle the story reveals, and you'll be well on your way to evolving skills in designing and delivering therapeutic metaphors. Accumulating lots of different stories that each illustrates a common therapeutic theme can raise your confidence in believing that perhaps you really do have a lot of worthwhile things to say.

SUMMARY

Each of the half-dozen patterns of hypnotically based intervention described in this section has been presented in a general way to acquaint you with some of the possibilities inherent in the process. Many of these patterns will become especially evident to you when you read them in clinical context in the sample hypnotic transcripts in the next chapter.

There are numerous components of each process, and each must be considered and properly integrated for it to be effective. For a more complete understanding of the concepts and techniques of these and the hundreds, if not thousands, of ways to structure hypnosis sessions, other writings in these areas are invaluable. Many of these, of course, are contained in the reference sections at the end of the book. While the strategies included here are representative of some of the most effective and reliable hypnotic interventions, there are literally many thousands of other therapeutic strategies involving hypnosis. As you read more of the clinical and experimental research regarding hypnosis, you'll learn many of them, and your range of treatments will diversify.

ADDRESSING COMMON CLINICAL CONCERNS WITH HYPNOSIS

In clinical practice, even therapists with a specialized professional focus encounter a wide range of presenting concerns. Some problems are rare; others quite common. This section contains a brief and superficial consideration of six of the most common clinical concerns and some quick ideas for how hypnosis might be used directly or indirectly in their treatment. It must be considered essential to your training in hypnosis to regularly read the key journals in the field, the abstracts of which are online and couldn't be easier

to access. The relevant information for doing so is found in Appendix A. The state-of-the-art research that informs good clinical practice is found in books, journals, and online articles as well.

Referring to Chapter 20's ideas on designing treatment plans and this chapter's discussion of symptom sequences, it may be helpful as you think about people's problems to think not only of what their symptoms are but also of how they generate them. The more you understand how people generate symptoms, rather than striving to hypothesize why, the more targets for effective intervention you will have.

Anxiety, Stress

Some have called this the "Age of Anxiety," and there is considerable justification for doing so. The number and frequency of stressors we face, largely due to the rapidly changing social, political, economic, environmental, and technological landscapes, leave less and less room for feeling calm. Personal safety, a core issue in anxiety, is uncertain when we're a nation at war and acts of terrorism can occur at any time in any place. The economy is in desperate shape, leaving too, too many wondering where their next paycheck is coming from and how they'll stay afloat. Just as soon as we get used to one technological advance, it becomes obsolete, requiring us to readjust. Traditional values holding society together have been and are continuing to deteriorate, emphasizing individualism and personal gain over social responsibility and making even the most important relationships seem only transient. Gender roles are much less specific, and committed marital and family relationships are taking second place to making strategic career moves, confounding many people trying to figure out how to make their relationships work. It's anxiety-provoking just reading these lines. The number of potential sources of stress in our lives keeps growing, and most people will struggle with these issues to one degree or another at some point in their lives.

Stress cannot be prevented, only managed, because life regularly throws all kinds of things at each of us. But, as often as not, stress isn't generated by external circumstances; rather, it's generated by subjective perceptions. These include unrealistic expectations, such as crippling perfectionism or rigid ideas about how others "should" be, a need for things to be orderly and predictable in rigid ways when too little of life is that way, a belief that you're too fragile or vulnerable to cope with problems, or any of a great many ways people torment themselves with their own internal issues. Hypnosis can be used to address any and all of these sorts of issues, not only calming people but also teaching more realistic thinking, greater flexibility, and better problem-solving skills.

One particular aspect of anxiety bears special consideration, if only briefly. It has to do with the foundation of anxiety. There are two separate but related structural components of most people's anxiety: (1) the tendency to overestimate

the risks one faces; and (2) the tendency to underestimate one's resources or abilities to manage those risks successfully (Barlow, 2000). Thus, teaching people how to more realistically assess the risks they face and how to cope with them skillfully can go a long way in reducing people's anxiety. The reality is, no place is truly safe, and many life experiences are inherently ambiguous, requiring us to manage them skillfully as they arise. Trusting yourself to do exactly that, rather than getting overwhelmed and fearful, is critical to keeping anxiety within normal limits. Using hypnosis to teach such critically important skills as risk assessment and personal resourcefulness are vitally important applications.

Hypnosis in its most superficial yet still helpful application in managing anxiety can help one build relaxation skills and an increased sense of self-control. Teaching clients the skill of self-hypnosis, hypnotic inductions and utilizations they can perform on themselves whenever they'd like to, is a necessary part of using hypnosis in clinical contexts with all clients. Simply knowing you have the ability to relax deeply and reorganize your thoughts, feelings, and behaviors can have a powerful effect in helping you better manage stress and anxiety. It's empowering to know you can take steps to deliberately shift your internal experience in beneficial ways. Managing anxiety effectively allows for better concentration, clearer thinking and problem solving, better self-esteem, better time management, better job performance, greater receptivity to new ideas, and better just about everything. Psychologist Carolyn Daitch wrote two excellent books, *Affect Regulation Toolbox* (2007) and *Anxiety Disorders* (2011), to help illuminate practical ways to manage anxiety.

Depression

Depression has been a major focus my entire professional life, having been my area of specialization in clinical practice and the subject of many of my books (Yapko, 1988b, 1989b, 1992, 1997, 1999, 2001b, 2006c, 2009), book chapters, articles, and clinical trainings. Depression is a very complex, multidimensional problem that, despite the development of effective treatments, continues to grow in prevalence. It is estimated that 20–25 million people in the United States currently suffer depression severe enough to require treatment, yet the majority of them will not receive the treatment they need. The World Health Organization (WHO, 2002) recently declared depression currently the world's fourth most debilitating human condition (behind heart disease, cancer, and traffic accidents) and predicted that it would grow to become the second most debilitating condition worldwide by the year 2020. This alone tells you how serious and how pervasive depression already is and what the future holds for too many vulnerable people.

There are numerous theories or models describing why people get depressed, but virtually all of them recognize three primary domains of contributing factors: biological, psychological, and social. In what must be seen

as a triumph of marketing over science, the biology of depression has been overstated, leading too many people to believe depression is the result of a neurochemical anomaly requiring medication to correct. As I described in my book *Depression Is Contagious* (2009), the evidence from many different areas, including neuroscience, epidemiology, genetics, and epigenetics, all point in the same direction: depression is more a social condition than a medical disease. The social factors leading to ever higher rates of depression across demographic and cross-national lines make it clear that focusing on neurochemistry alone is too one-dimensional and overly simplistic.

Psychotherapy for depression should be considered an essential aspect of treatment, since even the strongest medication advocates must admit that no amount of medication can teach coping skills, problem-solving skills, and social skills, can build a support network, or can do all the other things that are known not only to reduce depression but also to minimize the potential for relapses. Antidepressant medications may be valuable in some cases, to be sure, but should not generally be considered a sole form of intervention.

Hypnosis can be used in many different ways in treating depressed individuals. Many of the possibilities are comprehensively addressed in my books *Hypnosis and the Treatment of Depressions* (Yapko, 1992), *Treating Depression With Hypnosis* (Yapko, 2001b), and *Hypnosis and Treating Depression* (Yapko, 2006). There you will find detailed descriptions of specific hypnotic strategies, case transcripts with commentary and analysis, and in-depth discussions of key aspects of treating depression effectively. Possible targets for intervention might include depressed individuals' negative and demotivating expectations (i.e., hopelessness), the perception that no amount of effort will yield success (i.e., helplessness), cognitive distortions, faulty attributions, ineffective behavior, poor social skills, low frustration tolerance, poor coping skills, distorted decision-making strategies, global cognitive styles (also known as overgeneral thinking), and any of the many other subjective patterns of thinking, feeling, and behaving that can help form and exacerbate depression. Empowerment through sensible proactive behavior, called behavioral activation, is a basic theme in treating depression. Catalyzing behavioral activation by building positive expectancy and reducing paralyzing ruminations with hypnosis can be an invaluable part of the treatment process (Yapko, 2010).

Given how costly depression is on so many levels, and the especially troubling recognition that depression intensifies from one generation to the next, makes it urgent that clinicians know how to recognize and treat depression. Children and adolescents represent the fastest growing demographic group, and the earlier depression strikes in life, the more episodes one is likely to suffer. Depression is highly responsive to good treatment, and well-focused hypnosis aimed at the patterns that increase people's risk for depression holds great potential to be of help.

Relationship Problems

Considering the fact that the majority of marriages in this country end in divorce as well as the fact that more people today live alone and report loneliness than ever before, the indication is quite clear that people are having a harder time building and maintaining healthy relationships with others than ever before. Why? There are many reasons: the still changing roles of men and women that can make enduring relationships unnecessary, the diversity of family structures that might be convenient but may not always best serve their members, the increasing technological advances that keep diminishing our need for contact with others (e.g., more time texting, posting on Facebook, or "talking" in chat rooms instead of face-to-face contact), the ease of divorce, the economic difficulties of finding a good job without an education, which pushes back by years when you can start to consider having a family, the lack of good role models teaching the skills good relationships require (consider the terrible role models all over talk shows and trashy "reality" programs), the geographic mobility that makes it hard to get and stay attached when you're going to move again shortly, and the still casual attitudes about sex despite the spread of herpes, AIDS, and other sexually transmitted diseases. These are just some of the factors affecting each person's ability to relate to others in positive and balanced ways.

Good relationships don't just happen. There is much, much more to them than just "good chemistry." They require nurturing and a considerable range of skills including empathy, compassion, tolerance, impulse control, problem solving, negotiation, communication, self-sacrifice, and an attitude of protectiveness to name just a few (Gottman, 1999; Weiner-Davis, 2001; Yapko, 2009). In intervening in relationship problems, factors to consider include the quality of individuals' expectations (a primary determinant of their level of satisfaction such that when other people do as individuals think they "should" they are happier with them), the quality of their communication skills, and their subjective views on key issues like "power" and "intimacy." Often, the partners in a relationship have inadequate communication skills, poorly defined or even inappropriate expectations, more interest in being "right" than effective, more investment in advancing themselves than the relationship, and other such barriers to building an effective relationship. Hypnosis can be used with couples to build skills, to enhance communication, to increase empathy and attunement, to reduce anger, and to establish healthier patterns of relating (Kahn, 2010; Kershaw, 1992; Zarren, 2006).

When working with couples and families, you may be less likely to employ formal hypnosis, although hypnotizing one member in front of the others or hypnotizing the whole group can easily be done if you think it an appropriate intervention (Loriedo & Torti, 2010). Much more likely, however, is the use of informal hypnosis, using hypnotic strategies, such as metaphor, imagery,

symptom prescription, or role playing, to focus and absorb family members on ideas and perspectives you present to them that are meant to empower them to be more effective in their relating to one another (Haley, 1973; Parsons-Fein, 2001; Robles, 2001). Many clinicians will see couples or families as a unit and then see the members individually. Hypnotic strategies may then be employed to clarify expectations, to increase the level of motivation to resolve differences respectfully and skillfully within the relationship, to enhance communication skills, and to address self-limiting patterns that interfere with the growth of the relationship (e.g., increasing empathy, frustration tolerance, impulse control).

Even when partners and other family members are not available to do couples or family therapy, you can still do a *systemically informed* intervention, taking the roles and effects of others into account in the therapy. Healthy relationships serve as a buffer against all kinds of disorders, emotional and physical, and so are an important consideration in multidimensional treatment. Using hypnosis to enhance clients' relationships can also enhance the therapy relationship.

SELF-ESTEEM PROBLEMS

Self-esteem is the subjective assessment of people's value as a human being. It is formed in part by the feedback people get from others, but it is formed to an even larger extent by their beliefs and how they serve as filters for the feedback received. You may recall the earlier discussion of cognitive dissonance and its implication for the experiences people will and will not permit themselves (Festinger, 1957). If you think you're no good, then other people telling you that you are good will not likely change your view of yourself. Cognitive dissonance leads people to filter out feedback that contradicts their beliefs about themselves, serving as the perceptual mechanism for maintaining what may be an unfortunate status quo.

Self-esteem has been the target of many therapists' interventions. They have (erroneously) believed that most problems stem from poor self-esteem and thus made raising clients' self-esteem a primary therapeutic goal. In fact, self-esteem has risen over time in young people, and as psychologist Jean Twenge (2006) points out in her superb book *Generation Me: Why Today's Young Americans Are More Confident, Assertive, Entitled—and More Miserable Than Ever Before*, higher self-esteem, when rooted in inflated self-regard and associated with an exaggerated sense of entitlement, has made for greater self-absorption and poorer relationships with others and more unrealistic expectations for the self.

In this regard, self-esteem has been vastly overrated, and focusing on it as a culture may have been more damaging than most realize. Self-esteem is a statement as to how people feel about themselves. Good self-esteem is not an indicator of being more socially aware or skilled, or a better, more compassionate person, or more skilled in any way. It just means feeling good about oneself. Some of the most seriously disturbed or malicious people on

this planet, such as full-blown sociopaths, have quite good self-esteem. They are dysfunctional or destructive people who undeservedly just happen to feel good about themselves. Healthy self-esteem, however, involves a clearer self-awareness and a respect for others as well, making developing good self-esteem a worthy endeavor.

Helping people become more skilled is a more expedient path to raising self-esteem, though, than is simply telling people how "special" they are. I want my clients to be able to move through their day being effective in what they do, allowing them to say to themselves many times during the day, "I like what I did there. I like the way I handled that." Self-esteem rises as people develop, utilize, and notice their skills in living. Self-esteem comes from deeds, not entitlement.

When you work with self-esteem issues hypnotically, clients can be encouraged to take control of situations by planning and implementing a deliberate and effective course of action. They can learn that problems are caused not by fatal flaws, but by a lack of salient skills, ones that can be learned (Andreas, 2002). Absorbing them in learning alternative ways of addressing the issues in their life and solving problems while also teaching broader skills in problem solving are fundamental components of good therapy. Hypnosis can be structured to enhance skill acquisition, to encourage a willingness to try new behaviors, and to empower people to feel better about themselves as they come to better "own" the positive changes they make. Hypnosis can also help clients learn to generalize skills to other areas of their life.

Sleep Disturbances and Insomnia

Insomnia is the most common complaint associated with both anxiety and depression, the two most common disorders clinicians are asked to treat. Individuals may complain of having difficulty initially falling asleep or staying asleep, the latter condition manifesting as either middle of the night or early morning awakenings.

The negative consequences of chronic insomnia are substantial. Occupationally, these include a higher rate of absenteeism from work, greater use of health services, a higher number of accidents, and decreased productivity. On a personal level, chronic insomnia sufferers report a decreased quality of life, loss of memory functions, feeling fatigued, inability to concentrate well, and diminished interest in socializing or engaging in pleasurable activities, further increasing depressive symptoms. A sleep disturbance can increase the risk for alcohol-related problems. Survey respondents who reported sleep disturbances, more than 12 years later, had twice as high a rate of alcohol-related problems (Yapko, 2006b).

The use of self-help techniques, such as self-hypnosis, for enhancing sleep offers several key advantages: Self-help will not lead to either addiction or

dependence, it can be applied under all conditions, and it will not lead to potentially harmful interactions with other interventions.

The use of hypnosis in treating insomnia and sleep disturbances has been described in numerous clinical reports. Individuals suffering from insomnia can learn specific skills that will make a positive difference, including relaxation, good sleep hygiene, and decreasing rumination (repetitive thinking). Rumination generates both somatic and cognitive arousal, both of which can increase insomnia, but the evidence suggests cognitive arousal is the greater problem. Minimal cognitive processing and a relaxed focus on sleep are key treatment goals.

Hypnosis can teach people the ability to direct their thoughts rather than merely react to them. Reducing the stressful wanderings of an agitated mind and also relaxing the body while simultaneously helping people create and follow a line of pleasant thoughts and images that can soothe and calm them are valuable goals in the service of enhancing sleep. To achieve these aims, there are a number of important components to include in clients' treatment plan, including the following:

1. Teaching clients how to efficiently distinguish between useful analysis and useless ruminations—the single most important distinguishing characteristic is the conversion from analysis to action
2. Enhancing skills in time organization (compartmentalization) to better separate bedtime from problem-solving time with the well-defined goal in place of keeping them separate
3. Establishing better coping skills that involve more direct and effective problem-solving strategies
4. Addressing issues of sleep hygiene and attitudes toward sleep to make sure clients' behavior and attitudes are consistent with good sleep
5. Teaching *mind-clearing* or *mind-focusing* strategies, especially self-hypnosis strategies of one type or another, that help clients direct their thinking in utterly harmless directions

For a more detailed discussion of hypnosis in addressing insomnia, see Yapko (2006b).

Substance Abuse

Some of the most serious and pervasive problems in our society today are directly and indirectly related to substance abuse. Unfortunately, this is one of the least researched areas for applications of hypnosis. Despite the lack of ample clinical research, therapists regularly include focusing strategies in their work with substance abusing clients to address many of the key patterns regulating the abuse. Barabasz and Watkins (2005) summarized some of the available research, as did Cadegan and Kumar (2010).

Excessive use of alcohol and other drugs, cigarette smoking, and overeating are all examples of substance abuse. In each case, individuals are experiencing feelings, consciously or otherwise, that are uncomfortable, such as fear, loneliness, boredom, anger, or depression. Instead of dealing with the uncomfortable feelings directly and effectively, they typically employ an *avoidant coping style* (Abraham & Fava, 1999). Avoidance is an inherently disempowering strategy, placing one in the "victim" position by saying, in essence, "I can't handle this; the problem is bigger and more powerful than I am." People cannot hope to solve a problem skillfully by declaring themselves victims in this way. The substance is then turned to as a way of altering one's feelings, making them more manageable, even if only for a few moments.

Substance abuse also has a strong social component. People build their relationships around the substance and perhaps their identities as well. Treatment has to be as multidimensional as the problem. Using hypnosis to teach self-soothing strategies, better problem-solving skills, and greater impulse control are considered vital parts of treatment. Furthermore, addressing and resolving any underlying depression or anxiety are obviously important while regularly enhancing a stronger sense of commitment to sobriety or abstinence. These and many other such empowering skills are just some of the possible approaches in addressing substance abuse (Bell-Gadsby, 2001; Levitt, 1993).

On a different level of consideration, substance abusers typically are in a physically dissociated state to some degree, with a markedly diminished awareness of the negative effects of the substance on their bodies. Furthermore, substance abusers gradually build their lives around the substance: cigarette smokers don't generally take the stairs, and obese people don't typically look at their bodies in the mirror. Each group wants to avoid situations that will force them to confront (i.e., associate to) the physical effects of their habit, so dissociation from the body helps to allow the pattern to continue.

Hypnosis can be used to cultivate greater body awareness, a more positive attitude of self-protectiveness, and a greater sense of independence such that whatever situations are encountered can be dealt with more effectively without self-abuse.

Sexual Dysfunctions

The various sexual dysfunctions (e.g., erectile dysfunctions, premature ejaculation, disorders of sexual desire) can occur for a wide variety of reasons, including (1) misinformation about human anatomy or sexual functioning in general; (2) negative feelings about sex because of past negative experiences with it, such as guilt from a conservative religious upbringing or an abusive partner; (3) poor self-esteem and body concept; (4) poor quality relationships based, in part, on inappropriate expectations; and (5) organic problems result-

ing in impaired functioning as well as other less common reasons (Araoz, 2005; Klein, 2002).

A thorough physical examination is the first step in dealing with this and all the other problems present that may be organically based. Once the organic reasons for impaired or absent sexual functioning are ruled out, the clinician's task is to assess what psychosocial factors may be causing or contributing to the sexual problems. Some people can discuss sensitive sexual issues directly, in which case the clinician can also discuss them directly. But others are embarrassed, afraid, or otherwise reluctant to discuss delicate matters directly, so a clinician might reasonably decide to be less direct, at least initially, in his or her approach. In such cases, stories about other clients' problems can be useful in helping diagnose current clients' problems (the observant clinician can observe the ideodynamic changes in response to different parts of the story) as well as in offering therapeutic suggestions and directives.

People with sexual problems are generally in a dissociated state relative to their sexual functioning, rather than being fully associated to the pleasure of the experience (Araoz, 2001, 2005). There is a part of them attempting to engage in sexual activity, but their focus may instead be on other parts of themselves that distract or even distress them, such as a part that is observing and criticizing their sexual performance, or perhaps a part remembering past failures with the associated feelings of humiliation, or maybe a part that feels guilty remembering the shame of their religious upbringing, or even a part that simply feels angry with their partner for some real or imaginary hurt (Lemke, 2005). The result is diffuse concentration, mixed feelings, and a discomfort that dissipates the hypnotic aspects of the experience necessary to function well sexually.

Hypnosis may be employed to address and resolve clients' past hurts, to educate them about sexual matters, and to facilitate the process of reintegration so that all of the person may more easily be in the here-and-now, more fully experiencing and enjoying the sexual activity (Araoz, 1998). Another type of intervention is even more basic: altering sensory awareness by heightening kinesthetic sensitivity hypnotically. This is essentially an amplified "sensate-focus" technique that sex therapists routinely employ in the treatment of sexual dysfunction.

Anxiety about sexual performance is a primary target for hypnotic interventions in cases of sexual dysfunction. Anxiety causes poor performance, which causes more anxiety, which escalates the probability of poor performance, and so on in a vicious circle. Using the comfort of hypnosis to allow clients to "let go" is a good model for "letting go" during sexual activity, which is fundamental to sexual enjoyment. Teaching self-hypnosis to help clients control anxiety can allow the relaxation to generalize to the sexual context where they would like to have it.

Reframing sex as a natural, healthy function is an important suggestion that can be amplified hypnotically in sexual therapy. Giving the paradoxical directive (i.e., symptom prescription) to "avoid sex at all costs this week" can facilitate the "I'll show you by doing it!" attitude in mildly defiant clients (Haley, 1973). Changing personal history to teach a positive attitude toward sex (in the place of a negative one) while growing up is also a viable treatment strategy. Age progressing clients to see themselves as sexually active and satisfied is yet another potential application of hypnosis built on establishing positive expectancy.

Hypnosis and sex therapy are two highly compatible and easily integrated approaches to the treatment of sexual dysfunction. Given how sexual difficulties can strain even the best of relationships, this is an important area to address if we are to support good marriages and healthy families.

CONCLUSION

Hopefully, this chapter provided good exposure to some of the many ways hypnosis may be creatively and meaningfully applied in psychotherapy. Learning how, when, and where to apply the many different potentially therapeutic experiences available through hypnosis requires many years of practice and study. The deeper your understanding of the numerous components that are a part of each and every disorder, the greater the respect you can have for the overall integrity of the finely balanced system called "the client." And the deeper your understanding of how to define problems as solvable and treat them effectively, the greater will be your sense of skill and satisfaction with your chosen work.

FOR DISCUSSION

1. What are the advantages and disadvantages of individualizing treatment? Do they offset each other? Why or why not?
2. Can you identify a belief you hold to be true about yourself that has prevented you from having certain experiences? How did it do that? With what effect?
3. What evidence do you have that reality is subjective? Is there an objective reality? How do you know?
4. When, if ever, should clients be forced to deal with something directly that is intensely painful? Why do you say so?
5. Discuss what you think these statements mean: (a) Personal problems are a result of negative self-hypnosis; (b) All change involves hypnosis to some degree. Do you agree? Why or why not?

THINGS TO DO

1. Research a wide variety of therapeutic interventions in your field. How is hypnosis directly or indirectly a part of those interventions?
2. Have each member of the class identify as many euphemisms as he or she can (e.g., it's not a "used car"—it's a "preowned automobile"). How is reframing evident in each? What euphemisms exist in your field?
3. Have each member of the class tell a personally meaningful story of an experience in which a significant life lesson was learned. What is your internal experience as you listen? How does it compare with simply hearing the story's key point stated outright?

CHAPTER 22

TREATMENT DYNAMICS AND SAMPLE HYPNOSIS SESSION TRANSCRIPTS FOR COMMON PROBLEMS

In this chapter, the many pieces of the hypnotic puzzle that have been laid out chapter by chapter come together to form a full and revealing picture. Here I provide transcripts of clinical hypnosis sessions that illustrate how such sessions might be structured. Before going to the transcripts, though, there are two topics I want to briefly reemphasize for their importance in structuring interventions. The first concerns whether to focus on the content or process (structure) of a problem, and the second concerns the use of metaphor in the intervention.

CONTENT VERSUS PROCESS IN DEFINING THERAPEUTIC GOALS

A clear distinction was made early on between the content and process forms of hypnotic suggestions. Similarly, a distinction can be made between the structure and content of clients' problems. For example, someone may have a series of unsuccessful romantic relationships and report that he continually gets involved with the same type of "wrong" person: each was alcoholic, or

abusive, or emotionally distant, or "wrong" in some other way. Even though the names and faces are different (i.e., the content) from bad relationship to bad relationship, the way (i.e., the structure) he chooses someone to get involved with remains hurtfully the same.

Should the clinician focus on the details of each failed individual relationship that the person attempted and assume he has some unconscious personal pathology that leads him to sabotage relationships? Or should the therapist acknowledge that the person is motivated to have a relationship—he keeps trying despite painful failures—but clearly lacks the relevant skills for choosing a partner wisely and being a good partner, too? Shouldn't the clinician focus on the need to teach specific relationship skills, including how to assess others more realistically, choose more insightfully who to get involved with, and how to proceed with building a healthier relationship?

I invariably choose to use those approaches that not only help solve a problem but also teach the process of problem solving. To do this, spending an inordinate amount of time sifting through all the content-related details of a problem, in this case clients' specific difficulties in each individual failed relationship, is simply not necessary. If you introduce new and more effective ways to address a problem and make it practical for people to absorb and apply new concepts and methods, in this case how to make insightful and competent relationship decisions, on a structural level, the content must also change as a direct and predictable consequence.

It is a major decision point in the therapy process as to whether you would like to intervene on the level of content, the level of structure, or both. You'll notice in the session transcripts that I tend to favor a focus on the structure but will also use content when it serves the need to do so. In general, interventions addressing only the content level tend to produce the most transient results. Focusing on content can be useful, but only to the extent that it facilitates rapport and helps identify associated problem structures ripe for intervention.

USING THERAPEUTIC METAPHORS IN HYPNOSIS

There are many themes common to human experience that surface in the therapy context. This chapter will provide you with a few of them as they relate to particular clients with whom I did hypnosis. As you will note, these hypnotic processes make use of both direct and indirect suggestions as well as all the other suggestion styles and structures identified earlier. They also include the use of therapeutic metaphors, that is, stories I tell the client during hypnosis. From what you have already learned about metaphors in treatment, you know they are meant to first elicit and then to guide clients' internal associations in the direction of some therapeutic goal. Metaphors as a form of indirect suggestion can have multiple functions as listed in Table 22.1.

Table 22.1
Functions of Metaphors in Psychotherapy

Diagnosis
Establishing rapport
Treatment
• To make or illustrate a point
• To suggest solutions
• To get people to recognize themselves
• To seed ideas and increase motivation
• To embed directives
• To decrease resistance
• To reframe and redefine a problem

Source: Based on Zeig (1980b).

Table 22.2
Principles of Metaphorical Communication

Symptoms may be viewed as metaphorical communications
Metaphors may be therapeutic in their ability to match clients' indirect communication style
Metaphors contextualize learnings, bringing them to life
Metaphors allow for accessing of personal resources
Metaphors encourage a search for relevance, projection

Metaphors are both engaging and nonthreatening to clients because they are only indirectly related to their sensitive issues; this can make it easier for them to learn the relevant therapeutic principles in a less emotionally charged atmosphere (see Table 22.2).

Metaphors can be created quite readily when the underlying theme of the presenting problem has been identified. Table 22.3 provides some guidelines for the creation of therapeutic metaphors.

Perhaps the easiest metaphors begin with, "Once I had a client, not unlike you, who …" Such metaphors are encouraging to most clients, who seem to appreciate knowing they are not alone in their problems and also that you have previously successfully treated similar problems. If clients come to identify with the person in the story, the positive associations to therapeutic solutions can be more easily established. That is not always the case, however. As I discussed in *Treating Depression With Hypnosis* (Yapko, 2001b), clients absorbed in feelings of personal helplessness tend not to be inspired by others' success stories. Rather, they may feel worse as they conclude, "See, everyone else can do it but me."

Keep in mind that the use of metaphors is not a "given" in doing clinical hypnosis. All the guidelines provided previously about suggestion formulation must be taken into account. If you launch into a story with clients without

Table 22.3
Structuring Therapeutic Metaphors

Gather information including:
- significant persons involved
- characteristics of the problem, situation
- the desired outcome
- available resources to be accessed
- dimensions to be addressed (e.g., physical, cognitive)

Acknowledge previous attempts to problem solve, frustrations

Build metaphor or task analogous to problem
- select a context based on client interest
- isomorphic (structurally similar) characters, plots
- reframing of problem
- direct or indirect resolution suggestions
- discovery of alternate responses

Mapping metaphors
- number and sequence of metaphors on a theme

carefully evaluating their style and demeanor, you could create an avoidable problem for yourself when they confront you about wasting time talking about other people's problems instead of about theirs. The subsequent loss of rapport can hinder further treatment results.

SESSION TRANSCRIPTS

I have repeatedly emphasized throughout this book that the effective use of clinical hypnosis involves tailoring your approach to clients' unique characteristics. However, I also recognize the value of modeling as a teaching tool and so provide these session transcripts to illustrate possible wordings of goal-oriented sessions. I offer them with the caveat that they are not meant to be scripts to use with your clients.

The following session transcripts are derived from hypnosis sessions done with actual clients seeking help for a variety of problems. I hope you will study them with a thoughtful consideration of the personal, interpersonal, and contextual variables that likely led to the creation of the therapeutic suggestions made. You will be given some background on each of the clients, an explanation as to the goals for that particular hypnosis session, and how the session relates to the larger goals for their therapy.

As a final point regarding these sample transcripts, I have chosen to present in this chapter only those things that I said to the client to illustrate the various forms hypnotic suggestions may take. In reading the following transcripts,

your learning of hypnotic patterns can be enhanced by actively considering the suggestions offered and reasoning out the rationale for their inclusion. In contrast to the one-sided hypnosis session transcripts presented in this chapter, you have obtained with this book *The Case of Vicki*, the actual recorded session as well as the complete session transcript with commentary and analysis for a young woman with terminal cancer seeking pain relief through hypnosis. That session provides a fuller representation of how doing clinical hypnosis is a cooperative, interactional, and individualized process.

CASE 1: SELF-DEFINITION AND TAKING CARE OF SELF

The client is a woman in her early 60s who initially sought treatment for nightmares, recurring traumatic images associated with childhood episodes of molestation, poor self-esteem, and an inability to effectively set limits in her relationships with others. Supporting her working through the feelings associated with her traumas was one obvious and necessary part of her treatment plan. Another part of her therapy focused on her lack of a sense of self—what many clinicians call a lack of *ego boundaries*. Assertiveness and limit-setting capabilities are possible to achieve later in a therapy sequence, but first a sense of self worthy of protection must be defined. This woman was so global in her self-understanding and so selflessly adaptive to whomever she was around her that she knew shockingly little about her own thoughts and feelings. The following transcript represents part of a hypnosis session conducted quite early on in her therapy addressing the themes of building boundaries and evolving a clearer definition of self.

> All right, Molly, you can begin by taking in a few deep … relaxing breaths … getting yourself comfortable … getting yourself oriented now … to enter into internal experience for a while … so that you can really enjoy the balance between conscious awareness and unconscious awareness … let each breath relax you … let your thoughts run loose for a while … until they tire themselves out … and then little by little, they can slow … becoming very slow … so that more and more of your mental energy can be spent on learning … at the deepest levels within yourself … of the experience of comfort … about the experience of being so distant … from all the usual focal points of your awareness … so that you really can know deeply … that all the inner terrain … your inner landscape … can be traveled comfortably … looking at this natural formation … and that natural formation … the feelings and thoughts … the historical markers … your curiosity … and a very deep recognition … of inner capabilities … and it's interesting to observe the evolution … what the experience of development is like … to see a newly born baby … and no one really knows whether the baby thinks or what the baby thinks … and to watch an infant discover its own fingers, its own toes … to see the amused look

on an infant's face … when it discovers that it can make a finger wiggle … at will … and little by little … that infant learns … this is my body … and it is separate and distinct from any other part of the world … from all other people and places and things … and each square inch of your skin … is a boundary … between your inner world … and the outer world … and it really isn't possible for you to jump out of your skin … you are self-contained … and it's interesting … that there are some people who don't have a home in which to live … who believe that the sky is their roof … that the earth is their home … and then there are others who mark off huge territories, many acres of land … they clearly mark that it is theirs … and each wall someone builds … keeps something in and keeps something else out … and there are walls of stone … walls of wood … steel-reinforced walls … and there are the walls … that you can build for yourself … deliberately and happily … the walls of Molly … that are permeable walls … the kind that can selectively let things in and let things out … and it's that kind of a wall … that allows just enough distance from discomfort … to be able to drive down a freeway … comfortably … it is the kind of permeable wall … that when someone makes a comment during a conversation … that perhaps you can relate to … that permits a comfortable distance … a protective … distance from which to consider each bit of input … and you can feel secure that each person's feedback to you will have to check in at your front gate … before you decide to let it in or not … before you decide whether to react or not … and if you react … to decide how you'll react … based on what works … and feels good at the deepest levels within yourself … so, why not have a construction party? … and build a pretty wall … and a creative wall … and I wonder what colors you'll use … what materials you'll use … and what does the check-in gate look like? … and how very much room is there … for lots and lots of growth … and the walls … can always be moved when you so desire … they can be built up or built down … you can put in peep holes and panoramic windows … after all, the walls are yours … and all I know is that the ability … to walk into an open space … has at one level … unlimited freedom … but at another level … where's the structure to guide experience meaningfully? … and when I moved into this particular office that I'm in now … it was a huge space … I had to draft a plan … detailing how many walls I wanted … and where I wanted them … how many electrical outlets … and how many doors … and did I want the doors opening in or opening out … how many "on" switches and how many "off" switches … and there's a part of you that knows very well … that designing uses for space … is a real art … and you discovered over time … that each part of you … all the parts of you … have some space … and how you want to use that space … is certainly a matter of individual design … and the aesthetics … of a high wall here, or a low wall there … more space for this part and less space for that part … and you can really enjoy … the incredible clarity … that comes along … with increasingly sophisticated designs … movable and removable walls … and what a relief to know … that nothing that you experience need necessarily flow right through all of you … that you have lots of inner protection …

> walls of inner strength … and you've seen pictures of the Great Wall of China … and you've heard of the Wailing Wall … and you've read about the Berlin Wall … and you know about Wall Street … and maybe you've even heard about Wall Drug, South Dakota … and the natural wall of the Rocky Mountains … the sheer cliff walls of La Jolla … and with all the different possibilities … your unconscious can … without any real effort on your part … it can plan … and build … and if you were to work for a security firm … you'd really know about the importance of enforcing and protecting the walls that separate inner from outer … 24 hours a day … 7 days a week … one really must protect one's space … and well-being … and there are a lot of deeper meanings … that I really know … you can absorb and use … a day at a time … and so take your time … to process … to architect … and then … when you feel like you want to … and when you're ready to … that's when you can reorient fully … and open your eyes when you are ready ….

Multiple sessions were conducted with Molly emphasizing inner awareness, the recognition and acceptance of her own uniqueness, the ability to make positive choices in her own behalf, and the ability to deal with past traumas so as to permit future growth.

CASE 2: PAIN MANAGEMENT

The client is a woman in her late 30s who suffers chronic pain in her neck and shoulders, a consequence of a car accident in which she was rear-ended while stopped at a red light. She had several neurological evaluations prior to consulting me and was told that the pain would most likely eventually diminish, though not in the near future. The client is a professional woman who, as a result of her injuries and residual pain, is currently unable to work. She is married and in all other respects is a high-functioning, competent woman. She did not evidence depression or anxiety beyond what would be considered normal for her circumstances. Thus, other than instructing her in the use of dissociative techniques of hypnotic pain management over the course of a few sessions, further therapy was deemed unnecessary. The following transcript was from the fourth of five sessions.

> … Okay, Madeline … Are you comfortable? … (Nods) … Good … you can begin by taking in a few deep, relaxing breaths … and then whenever you're ready … you can just allow your eyes to close … so that you can begin now … to go inside … to be able to explore within yourself … find those most comfortable … thoughts … and feelings … that can allow you that very, very relaxed state … of mind and body … and you might remember … that you've experienced hypnosis comfortably with me before … and so I know from at least those experiences … as well as other hypnotic experiences you've had … both on your own and with others …

that you know from your own direct experience … what it's like to breathe comfortably … and to sit comfortably … what it's like to get so absorbed in your own thoughts … that for a little while you forget … that the rest of the world is going about … its usual business … and one of the most soothing, relaxing recognitions … is that you really don't have to pay attention … to anything other than what pleases you for the moment … and the nature of conscious awareness is such … that it will naturally drift … from here to there … and to nowhere in particular … and wherever your consciousness drifts to at any moment … is just fine … whether you notice the routine sounds of the environment … or your own thoughts … or your own reactions to the different things that I say … or the pleasing changes that take place in your body … as your mind drifts … to the different awarenesses … and it can be very comforting to know … that that is the nature of the conscious mind … it can drift in … and out … it can notice and not notice … it can think and enjoy not having to think … or having to analyze critically … and so it can accept easily … the different possibilities … and while your conscious mind is certainly capable of processing … whatever it happens to notice … the part of you that is infinitely … more interesting and powerful is your unconscious … the part of you that can listen … and respond … even when your conscious mind drifts elsewhere … and your own unconscious … has abilities that your conscious mind sometimes forgets about … and when you're conscious of your unconscious mind's abilities … and can consciously analyze and access … the unconscious awareness … of what your conscious mind knows and doesn't know … and what's easier to understand consciously than unconsciously … that's when you can appreciate the comfort of recognizing … how the mind and the body … can work so closely together sometimes … when that's important … and how other times … the conscious mind and the unconscious mind … can drift off elsewhere … and the mind's greatest ability is the freedom … to go wherever imagination wills it … and some people like the freedom of having their minds float through space and through time … others like to drift back in time to the comfort … of a very special soothing place … that's prominent in their memory … and is vivid in their senses … and the fact that your mind can drift off … way over there … while your body rests so peacefully … over here … is certainly an interesting experience … and sometimes people forget … how when their mind is drifting there … and their body is resting here … that their body can continue … to take care of itself … the automatic, unconscious … self-preserving … nature of your body over here … can give your mind the comfort over there … that allows a comfortable distance … that gives you the freedom to simply know how differently … you can feel … and when your mind drifts … that's when it's easy to not notice things that change … and I don't know whether you know yet that your breathing has changed … that your pulse rate has changed … and what it feels like to have … your body somewhere … close enough … to use if you want it or need it … but without impinging on the freedom … to float freely and comfortably … that light … airy feeling … and as you experience that interesting sensation … it can be very

interesting to discover … how easy it is to forget … to notice where your left foot is relative to your right … until I draw your attention to it … what it feels like to wear a wristwatch on your left wrist … it's easy to forget … what it feels like … to have earrings in your ears … or to have the chair supporting your body comfortably … and you know and I know … that the mind and body … are closely related … and so are thoughts and feelings … and so is past and present … but you're also very aware that things change … and that awareness offers … a buffer … a comfort zone … that leaves just enough room between the present and the past … to make the present of comfort a gift that you can enjoy for months to come … and the comfort zone … that rests comfortably neck and neck … between the present and the future … where the present can be just comfortable enough … to allow a future of feeling better … a day at a time … and you know that sometimes … people don't understand the relationship between past and present … anymore than they understand the relationship … between thoughts and feelings … but you have a feeling that your thoughts matter … and your thoughts about your feelings can allow your feelings some distance … a safe, comfortable distance … between what you experience now and what you felt then … and between your head and your body is a space of deep comfort … and what you're going to think tomorrow … but you'll have to wait until tomorrow … for your conscious mind to know … what your unconscious has already discovered … that it takes far more effort than it's worth … to move your hand … when it's so much easier … you can be so much more comfortable sitting beside yourself so much more comfortably … when your mind is here … and your body is here … and it's just enough distance to be so much more comfortable than you thought you could be … and you can be very aware … of that interesting sensation … of being separate from your body … and having all of yourself … in the experience of deep absorption … and you know and I know that as distant as your body feels on one level … it also feels close enough on another level … to be aware of its need to continue to breathe … in … and slowly out … so effortlessly … and so comfortably … and as your mind continues to float there … and your body continues to rest comfortably over here … your conscious mind can certainly be curious … about the comfortable sensations of feeling the separation existing … and you don't really have to analyze too carefully which part of you is the most comfortable at the moment … you can simply allow yourself instead … to enjoy the comfort that goes along … without really being sure … exactly … where your fingers are … or where your hair is … it can be very soothing to know that you can drift back … into an awareness of your body when you choose to … and that for the moment … you can simply enjoy the choice … of letting your mind be there … while your body rests comfortably over here … and I know that doesn't make much sense to your conscious mind … but fortunately … even though your conscious mind is very smart … your unconscious is a lot smarter than you are … and all the learnings of your lifetime … allow you the comfortable position now of being able to drift freely … far enough away … yet close enough to your body … to be so comfortable … in ways your conscious mind is only

> beginning to discover … and each time that you listen to this session or each time that you sit quietly with your eyes closed … your unconscious can add a new and interesting dimension to the experience … your overall awareness … of your ability to be as close to or as far away from … your body as you'd like to be … and when you recognize … powerfully within yourself … how much more control you have than you ever thought possible … then you can enjoy the feeling of comfort … that you really can rest comfortably … and that you really can heal surprisingly quickly … now that more parts of you have begun some work on the job … and so, Madeline … I'd like you to take your time … and reorient yourself to whatever degree that you wish to … in order to bring … yourself out of hypnosis to whatever degree you wish … and by that, I mean that if you choose to keep your body absorbed while you bring your mind out of hypnosis … I can certainly understand that choice … or if you choose to bring your body out of hypnosis … but leave the comfort intact to enjoy the rest of the day … I can certainly understand that choice … and whatever choice you make … you'll certainly be aware … that when you allow your eyes to open … you'll be ready to get on with the rest of today in a much more comfortable state of mind and body … and that will certainly be an eye-opening experience.…

The suggestion of being able to keep her body comfortably in hypnosis while in a "waking" state was one that Madeline found especially useful in helping her carry out routine activities. The many suggestions throughout for disorientation and dissociation (mind and body, conscious and unconscious, past and present, and body parts) facilitated a very deep experience of hypnosis that permitted substantial relief from pain throughout her lengthy recovery.

CASE 3: GOAL (FUTURE) ORIENTATION

The client is a man in his late 50s who presented the problems of "being stuck" in an unstable "on-again, off-again" relationship that he finds distressing, having high blood pressure, and procrastinating around issues of his career. He presented as "wanting to achieve enough personal growth to be able to move forward with my life." He did not have any specific goals in mind as to what would represent "moving forward." If the client's goal isn't well defined and if there aren't specific steps to follow to achieve it, then it isn't really a goal. It's only a wish. Thus, one goal in this client's treatment was to help him evolve a clear sense of direction in his life. During the course of treatment, hypnosis was utilized to encourage the development of a clear and specific sense of the future, enough to compel him to take some decisive and progressive courses of action in the present (behavioral activation). The client is an educator who claimed to be well acquainted with clinical hypnosis in general and the work of Milton Erickson in particular. This transcript is from the third of a dozen sessions.

… Okay Jerry, you can begin by taking in a few deep, relaxing breaths … and little by little … you can let the various recollections … drift through your awareness … of what it's like to be in deep hypnosis … in a way that's pleasing and comfortable … and it's been quite a while … since you last experienced … a formal hypnosis process … with me as guide … but there was a time … not all that long ago … when you first became accustomed … to hearing my voice … get quieter … to hearing me … speak in a very slow … deliberate way … and it was during that initial experience … when you were first beginning to learn something about hypnosis … and were open to much deeper possibilities … that you allowed yourself to experience … some of the most interesting dimensions … of doing hypnosis … and since quite some time from our first hypnosis session has elapsed … and since you've grown in so many ways since then … it can certainly be much easier … to drift into a deeper experience … and a much more comfortable state of mind and body … moment by moment … and this is one … very worthwhile opportunity … to rediscover … your ability … to drift … in a way that's useful … in a way that's meaningful … and I know … that the various possibilities … as you explore your experiences … can certainly be most intriguing … as the various possibilities … allow you to rediscover … old awarenesses … that pave the way for new awarenesses … and as the new awarenesses drift … into your consciousness … that's when it's so easy … to discover how little attention … is necessary … to allow all kinds of comfort … that we can build upon … in a future experience … of each day … and I'm aware that your mind is drifting … to nowhere in particular … that the things that you think about at this moment … are tied … to past experiences … and future expectations … and you know and I know … that so often … if the seed … can get planted today … it generates the greatest amount … of worthwhile … future possibilities … and as Erickson correctly pointed out … you can't change the patient's past … you can only change his perspective of it … and how much the past relates to your future … you'll presently come to know … because it's the present that is connected to your past … and leads to your future possibilities … that you're willing to explore … and your presence here … confirms that … as you make yourself the present … of a positive future … that wisely incorporates learnings of the past … of things that you experience presently … and all that talk about past and present and future … isn't really meant to disorient you in any way … that might be worthwhile … but it certainly can help you … in seeing the perspective … that the impulses of the moment … can be looked at differently … as you discover … that the most worthwhile things to be made … you can make on the inside … from within … in your deep self … your deep self … and if you think back … through the worthwhile things that you've already experienced … few of them came easily … for the simple reason … that whatever you've obtained … you've worked for … and there were so many times … on your way to becoming a teacher … that it would have been so much easier … to skip class … and go play … to go to the beach … or to go for a run … and you certainly would have been justified in doing so … but you felt deeply … there was something more important to be gained

… in the name of sacrifice … and every self-sacrifice for self-improvement really isn't much of a self-sacrifice … because when you think about the relationship between sacrifices and improvements … and you improve the sacrifice … and you sacrifice less than you improve … you really haven't sacrificed … you've just improved … and gone a step further … and the questions from within … that generate the momentum to grow … and experience … is a dwindling internal pressure … that each new experience can comfort … each new opportunity … for growth … can be recognized for what is … and there's been so much that you've learned over time … so many ways that you've changed … and as each change pressured from within equalizes the pressures outside … by responding deeply to the appropriate demands from inside … you've become so skilled … and the results have shown … and you can have a very powerful impact … when you allow yourself … to release … maybe to teach … in a sharing way … what you already know … and going to school is only one way … to evolve … and change … in a giving way … that leads to a greater sense of self … than anything you've experienced before … and all through your past … there was self-sacrificing … that had an aura … of taking care of yourself … beneath them … and when one becomes a parent … it's apparent … that the selflessness of parenthood … is the shiny surface … of a selfish decision … to have children … that one hopes will reflect one's self … with pride … and accomplishment … and the debate about the selfish nature of the selfish decision to have children … continues … and the sacrifice … of a loving relationship … that gives you what you want … and you know what it means to give … in order to get … and whatever you may have to openly give … grows … easily … and as you understand more and more deeply within … that giving to get … is the greatest way … to build a solid relationship … especially with yourself … especially … with yourself … and so … why not … selfishly and selflessly … sacrifice a little bit of time each day … to give to yourself … in order to get from yourself … a much more comfortable … and much less pressured … way of doing things … a much less pressured … way of circulating blood … in a body that's so healthy … with comfort … and the ability to relax deeply … and you know from the people that you work with … that you can pretend that they're not listening … but you know that their unconscious is … and they can pretend they're not listening … but don't you be fooled by it … because there's a part of each person … no matter how educated or otherwise … that has the ability to learn … and to grow … and to change … and someone can work hard at staying the same … but you know and I know that change is inevitable … and so don't you be fooled by it … and I'm going to be silent for a minute … as you explore within yourself … the thoughts and feelings … that pass through your awareness … that become significant for you in ways that your conscious mind has yet to discover … and when I again speak to you in a minute … my voice can just relax you even more deeply … and the minute of silence begins … now … (one minute of silence) … that's right … you can just continue to relax … to continue to be at ease and resting comfortably … and you've allowed me to be aware … of the multiple purposes of our session … learning

> opportunities and personal growth opportunities … professional growth … and meaningful experiences … and I wonder how much you'll be able to discover … from these focused experiences … as you notice the different ideas and the different perspectives … and you can enjoy knowing … that each hypnotic process … will have a different effect … and generate a different pattern … in ways that your unconscious … can unconsciously allow … while your conscious mind looks forward … to discovering … the range of possibilities … a day at a time … and so, take whatever time you'd like to … to process your thoughts … the different dimensions of your experience … and to think about your expectations … and which learnings will be most appropriate to utilize … this week … and which learnings can wait until next week … and then, whenever you're ready … you can begin to reorient yourself to here and now … this room and this place … and whenever you'd like to … you can slowly move to reorient yourself … and then you can allow your eyes to open …

The client reflected on the basic truth that anything he had of value he worked hard for. He was easily able to recall what seemed like a sacrifice at the time when he was in school taking classes while others were out enjoying recreational activities. The session motivated him to directly confront the aimlessness in each of the areas of his life and led to later sessions addressing issues of goal-setting, setting aside immediate gratification while striving for worthwhile future possibilities, and being more responsive ("giving to get") in his relationship.

CASE 4: ADAPTABILITY

The following transcript is of a hypnosis session conducted with a psychologist in his mid-50s attending one of my clinical hypnosis training courses. While he found the concepts and techniques of clinical hypnosis highly illuminating as a model for better understanding people's subjective experience relative to psychotherapy, he was having difficulty shifting his perspectives about doing therapy away from his established psychodynamic orientation. During a demonstration session in the training, he asked to have a hypnosis session to help him better assimilate the new learnings and to evolve greater flexibility in his treatment approaches. Thus, this session was done before the other class members in a context defined as more educational than clinical. It was the first and only time I worked with this man.

> … Ben, you can arrange yourself in the most comfortable of positions … and then a little at a time … you can orient yourself to the possibility … of being very relaxed … very comfortable … very much at ease within yourself … and I know that it was Ernest Hilgard … who formulated the idea … that a person's ability to be hypnotized … to go into deep hypnosis … was a fixed characteristic … one that really wouldn't change much over

time … and I wonder whether you're discovering … a good and satisfying basis for disagreeing with Hilgard … perhaps discovering that people can go into deeper hypnosis … reaching deeper levels more quickly … through practice … through experience … and you may be interested in knowing … just how deeply into the experience of hypnosis you can go … or just how quickly you can reach … a very comfortable level … within yourself … it really doesn't matter much … whether you focus on depth … or speed … or Hilgard … or yourself … all that really matters … is the enjoyment that goes along … with discovering that at all levels within yourself … that you really can be comfortable … and I know that it's important to you to have your mind be active … to think and to analyze … and to always be oriented … to as much of what's going on around you as you can … that's the pattern … that you've evolved through a lifetime of learning … and analyzing … and you know and I know … as mental health professionals … that sometimes people are the masters of what they learn … and other times … people are the victims of what they learn … and each time that you take time to learn something new … you have a chance … to integrate it with what you already know … deeply … and I don't know how much you know … about what you know … about what Milton Erickson knew … about what he knows … and how people know what they know … and don't know about what they don't know … and a famous humorist once said … it's not what you don't know … that's the problem … it's what you know that ain't so … and Milton Erickson … a gentlemen that you're by now familiar with … didn't really believe in formal theories of personality … Milton wouldn't be the one to describe your patterns as … obsessive or compulsive … he wouldn't be the one to label a person with a particular name … and yet … some people insist on doing exactly that … and I worked in a hospital long enough … to know … that doctors will say … how's the broken leg in room 210? … how's the hip replacement in room 325? … how's the mood disorder in room 104? … as if no one has a name anymore … no one is a person … just a label … and it was Erickson's belief system … and I wonder just what you think … deeply … in reaction to Erickson's observation … that while your unconscious has … ample resources that can be used to help facilitate changes … in yourself and in others … it's the learned limitations … the learned limitations … that reinforce what Erickson referred to as rigidity … of patterned behavior … that a person learns a certain sequence … a certain style … a certain response pattern … and then that's what he does over and over again … in a very rigid sort of way … and when you suggest a deviation from that pattern … you may get resistance … and when you suggest that someone step outside … the boundaries of his patterns … you may get resistance … and it isn't until someone breaks his own pattern … by responding to the same old situation … in a new way … that the most meaningful changes occur … and there are rigid thought patterns … rigid emotional patterns … rigid behavioral patterns … rigid social patterns … rigid therapy patterns … dynamically speaking … stereotyped responses in specific situations … and why not step outside … the usual boundaries … why not demand a new response from yourself in an old

situation … why not do something new and different … and enjoy the new and different results … and enjoy discovering … that you really can be flexible enough … to respond differently … in ways that are only first being discovered … by your conscious mind … and I wonder how many new things you can do today … and how many out of character responses you can generate today … and can you be flexible enough … to respond differently … and when your usual level of tension gave way to the deep relaxation you obviously have now … that's a very comfortable change in pattern … and when discomfort becomes comfort … that's a change, also … and little by little … you're beginning to discover … new possibilities in old situations … in ways that can feel so good … on all levels … and why not … allow yourself … a different response … perhaps a comfortably less dynamic one … in that situation where it would be most helpful … and least restrictive … opening the door to new possibilities … and closing the door … on learnings that keep the door closed … a day at a time … and so take your time … process the part of my message that your conscious mind can understand … safely … and pretend if you'd like to that there aren't any deeper meanings … for your unconscious to learn … and then when you feel like you're ready to … and want to re-orient to here and now … you can begin that process … of bringing yourself … to a different level of responses … and when you're ready to … you can just allow your eyes to open.…

After the hypnosis session, the demonstration subject reported being aware of an important reframing that had taken place for him during the session. He claimed he had not thought of his therapy approaches as "rigid." Rather, he had simply thought of them as "proper procedure." In hearing his patterns described as "stereotyped responses" and absorbing the idea that growth comes from "stepping outside the usual boundaries," he reported feeling a freedom to experiment he had not previously felt. Over the course of the remaining days in the course, he commented several times on the "liberating effect of having more ways to conduct therapy."

CASE 5: WEIGHT MANAGEMENT

The client is a woman in her early 40s, employed as a computer programmer, who presented the concern of wanting to maintain the weight loss she had succeeded in obtaining through a structured weight loss program she participated in. She had been able to gain control over all of her troublesome eating habits, with the exception of snacking on bread, particularly French sourdough baguettes. She wanted to be able to develop moderation in her bread intake, much as she had with the other foods in her diet. She is a woman who values logic and has a long history of being fairly dissociated from her feelings. This transcript represents the second of three sessions.

… All right Gerda … you can take in a few deep, relaxing breaths … and orient yourself now to inner experience for a while … somewhere … a little deeper than rationality … somewhere beneath … logic … somewhere to the right of your left brain … somewhere above … everyday living … and when you're above and below … the right of things that are left … then every direction provides a new opportunity or deeper sense … of comfort … and for a very long time … you've had many experiences of being able to think rationally … to relate at a deeper level … to the logic of computers … the sequencing of programs … all exercises … for the intellect … but you know and I know … that the true balance of things … rests … on continuous movements … continuous minor adjustments … in daily experiences … that move us from balance to imbalance … back to balance … hoping and adjusting … and all of that … about imbalance is very heavy … and balance is light … red light … blue light … white light … light feelings … light beer … light air … light thoughts … and what makes something that's heavier than air … float … and which part of your body is lighter? … left side … or right side … top half … or bottom half … the front of your back … the back of your front … you really don't know … but when you experience … the kind of uplifting experience … that really raises your awareness … for how distant one part of you can seem … while another part seems to float … right in front of you … and if thoughts are over here … and feelings are over there … then you might … be oriented to a disorienting experience … and whether it's temporal disorientation or physical disorientation … being oriented to how disoriented your body can be … then you're oriented to thought … and have you noticed how disoriented your thoughts can be when you're so oriented to your body … and it can seem so close and yet so far … and you can think you understand and that you know what you hear … but if you don't know what you hear when you're here then maybe you know what is there … and when you play … that light … carefree feeling returns … and your thoughts can smile … and what a sensation when your body giggles … and which part … experiences humor? and what about … being disoriented to the usual cues … the usual patterns … that you'd really like to scale down … and lightening up allows for that possibility … and remember once I described to you that the ocean has the ability to maintain itself … and at a much deeper level … your unconscious is learning nature's way of maintaining a body … of water … and how much of the body is water? … and you know when there's chemistry … which molecule … and which atoms … have a natural attraction … and what is the chemical makeup … of sourdough bread in comparison to rye? … and when they bag it (baguette) … to take it home … any change in your deeper structure provides an interesting opportunity for growth … and that's an awful lot to digest … in one sitting … but when the conscious mind is overloaded … that's when the unconscious gets to enjoy the spotlight for a while … and that's when it can really shine … and I don't know if anybody really knows why that's true … all I know is … you have a conscious mind … that's very smart … and an unconscious mind … that's even smarter … and I remember … a colleague of

mine named Jeff Zeig telling me once … that Erickson told him once … that variety … is the spice … of life … but he said it a little differently … he sat Jeff down … and he said that each person enjoys meals differently … some really enjoy seven course dinners … and which course is the right first course? … some enjoy soup … followed by salad … some prefer it the other way around … and one might enjoy … something to cleanse their palate with … and which side dish goes with which main dish? … and I knew one individual who enjoyed dessert first … which I thought was a very heavy, weighty decision to make … but with each person there are differences … and Erickson droned on and on describing … how many different ways there are to eat in a way that's healthy and satisfying … he finally led to the conclusion that if man cannot live by bread alone … then a woman probably shouldn't either … and when Jeff was working too hard … Erickson reminded him … there's more to life than protein … and how does an unconscious mind understand deeper messages? … and translate them into subtle changes that really feel good … well, let your conscious mind chew on that for a while … and if you ever have the experience of being crusty and discovering yourself taking it too seriously … there will come an opportunity to remind yourself … that when you don't understand why you do what you do … that's the time for the services of a good translator … or perhaps a trance now … I don't know which … but I do know … that it could be the feeling … of amusement guiding you … it doesn't detract from the significance of what you've learned … it can be the lingering feeling … long after … of feeling good about what you've done … and whether you'll remember that … consciously or unconsciously … or both … you really won't know … until you reorient in a moment … and find your eyes opening … to discover what you know … that's different … take your time … before you have that eye-opening experience.…

The client's response to the confusional suggestions was an amused detachment that highlighted to her how impactful things on a nonrational level could be. Given her usual emphasis on logic, a pattern that did not assist her in losing weight or keeping it off, she found it meaningful to discover how subjective and malleable her experiences really are. She made frequent use of the recording of this session that was given to her and found the phrase "woman cannot live by bread alone" coming back to her in a light-hearted way when passing by the bakery where she normally stopped and bought bread. The use of humor in the session associated a positive emotional tone to the content of the session. As with all patterns, humor must be used selectively.

CASE 6: STRESS MANAGEMENT

The client is a man in his mid-30s who presented the problem of "too many things raining down on me to cope with." He was undergoing a major shift in

responsibilities in his job as an administrator in a construction company, his first child (age 4) was suffering health problems, and his wife was pregnant with their third child. He felt as though every domain of his life was unsettled and a source of stress and wanted to learn to manage stress more effectively to prevent any debilitating effects. He shared his fantasy of escaping to a Caribbean island and wished there was a way to prevent stressful events from happening in his life. The following transcript represents a hypnosis session done in the first of seven sessions.

> … All right Ken, you can begin by taking in a few, deep relaxing breaths … and you can begin now to orient yourself … to the possibility of feeling … very comfortable … and very relaxed … and little by little as the world goes on as usual around you … why not make yourself really comfortable … of course the more absorbed you get … in your own inner experience … the less it really matters what's going on in the world around you … everybody needs a little bit of time away … a little bit of a break … to turn their attention in a different direction … and one of my favorite television shows is *M*A*S*H* … I still watch those old reruns from time to time … just to revisit some comfortably familiar times … and I don't know if you're a fan of that show or not … but it will happen from time to time … that the *M*A*S*H* hospital … will be shelled by the enemy … and numerous explosions take place … as the shells rain down … and everyone runs around scared and overwhelmed … unsure if they'll be able to survive … and you can imagine … how fighting for your life … can be a very serious battle … and then what always happens at some point along the way … is that the shelling stops … and someone will offer the comment … to listen to the silence … (pause) … and in living life each day … the shelling takes a lot of different forms … the shelling can be hassles with other people … concerns about the environment … doubts with one's self about what one should do … the battles can be inside … they can be outside … they can be brief … they can be tolerable … they can be inspirational … they can cause growth … they can foster creativity in finding ways to see beyond the moment … but there also come quiet times … times when all the hoopla is over … when the noise stops … when your thoughts slow down … and when nothing really seems to matter very much … and it's those quiet times that prepare you so well … for the times that aren't so quiet … the few seconds that can feel like a lot longer period of quiet … they restore comfort … and balance … that strengthen you … for any … and all future occasions … where patience and understanding … might work quite well … and right now you're in one of those periods of silence … and the world is so unpredictable … it's hard to know … whether things will still be quiet … next week … next month … next year … and it really doesn't matter … all that really matters … is how you use your quiet period now … whether you use the time to strengthen yourself … and pamper yourself … to congratulate yourself … and to appreciate your ability to grow and do much more than just survive … and for a while when I was much younger … I had the experience

of living on the island of Jamaica … I lived in a very small village … on the west end of the island … where very few Americans actually go … and nobody there knew how to read … nobody knew how to write … nobody was informed about world events … the locals were shocked and disbelieving … when I described to them how Americans had put men on the moon … and brought them back safely again … and despite their ignorance … there was a certain satisfaction … in understanding the island on which they lived … where most of the time the sky is so clear and blue … but as is typical of the tropics … every once in a while … huge clouds would roll in … and there would be heavy rain and thunder and lightning … and then the clouds would roll out again … and at first I found it very unsettling … that unexpectedly … my enjoyment of the sunshine … could be interrupted at any moment … and obviously, I had no control … over thunder … and rain … and you learn very quickly … that the loudness … can be so well appreciated by the counter balance of quiet … and that it's the loudness … that makes the rain forest come alive … and allows the growth to take place … and sometimes it's inconvenient … sometimes it seems unnecessary … but the fact of the matter … is that the darkness of rain … leads to the lush vegetation's growth … that permits the pleasure … and all things are balanced … and how good it feels for you to be settled comfortably … and how well it prepares you for periods of being unsettled … just as periods of being unsettled … allow you to really appreciate … settled, comfortable times … like now … and why not enjoy … quiet times … and appreciate what they have to offer … and why not accept the inevitable … that rain falls … and people change … and things get better … a day at a time … as you grow more tolerant … and enjoy greater periods of comfort and stability … it can grow easier and easier … to move flexibly and fluidly … through the rain and through the shine … whether you're in Jamaica or San Diego … Europe or Africa … the sunshine on the inside … makes it easy to deal with the rain on the outside … and someone once said … no news is good news … but you'll have to make your mind up about that for yourself … and taking the time to enjoy feelings of comfort … to enjoy the quiet inside … how good it feels … to know … that the shelling has stopped … and experiencing the comfort … is certainly a privilege … and so why not carry it with you everywhere … everywhere that comfort is permitted … and share some of it and keep some of it … let some go … hold on to some … and as you begin the process of reorienting yourself … bring just enough back with you … to enjoy the quiet … and then when you feel like you're ready to … you can quietly open your eyes.…

The client found the hypnotic process "a good break" from the routine pressures he faced, and found it interesting that I would reference *M*A*S*H*, which, as luck would have it, is one of his favorite programs. He thought of Hawkeye in particular and how he uses humor to stay sane in an insane situation. He decided that he would act similarly and gave himself the assignment of making a point of telling jokes to people as a way of easing tense situations. He

thought that approach to be a positive stress-management tool in addition to the self-hypnosis he was taught and related it further to things he had read about humor and healing. Subsequent sessions involved addressing specific problems needing his attention.

CASE 7: COMPARTMENTALIZATION

The client is a woman in her late 20s who presents the concern that she is "too emotionally volatile." She blows up at people with little provocation and routinely finds herself wondering why she does that. She is a global thinker, one who metaphorically "sees the forest but not the trees." In plain language, she doesn't break experiences down into their component parts to decide which part of an interaction, if any at all, to react to. Instead, she reacts instantly, and with full force. Thus, the primary goal of this session is to encourage a moment's pause (impulse control) to follow a suggested template of deciding what's most important to respond to in a given moment. This requires an ability to compartmentalize experience, that is, break a global experience, such as an interaction in which she's feeling emotionally threatened in some way, into its component parts to determine which part to respond to and which part of herself to respond from. This is from the third of four sessions.

> You can begin by taking in a few deep, relaxing breaths … and as is starting to become familiar to you now … you can begin to recapture a sense of growing quieter inside … each breath … relaxing you … a little more deeply … enjoying the simple rhythm … the symmetry of breathing … each breath in … taking in a deeper level of comfort … and each breath out … letting out … what you really don't need … and so each inhale … allows your body … to grow more comfortable … each breath out … is a release … allowing you the comfort … of knowing that this time is for you … this experience is for you … and that you've created this time … to just … provide some space … space to relax … some room to learn … and grow … from things you hear me say … and more importantly … from things you come to realize … and when you have an experience like this one … there's a moment by moment … flow … to your thoughts … a moment by moment … flow to the session … and at the same time … it isn't all the same … it isn't just a relaxation session … although it certainly is that … it's more … much, much more … because when you have an experience like this one … there are so many different aspects to it … there's the internal dialogue, what you say to yourself through your thoughts … the running conversation in your mind … there's the external dialogue … my voice … my words … reassuring you … encouraging you … there's the external environment … the routine aspects of life that go on around you … whatever those external factors might be … whether it's the sound of the winds in the tree or the distant sounds of traffic … or the sound of a dog barking or kids playing … or even just the sounds of

the stillness of the environment … but all that's outside … and there's the internal environment … the quality of feelings … that you experience as your body relaxes and as your thoughts begin to slow down … and you start to experience the comfortable flow … of just being with yourself in a way that's … easy … and relaxed … and it's an important realization … that whatever experience you happen to be in … that there are many different components … many different components … when you watch a movie … you're not just watching a movie … there are many different components … certainly the images that flash across the screen … the things you watch … but those images … are a trigger … a catalyst … for emotional reactions … as you react to the things you're watching … so when you watch a really funny comedy … the humor that leads you to laugh without effort … the silliness, the absurdity … what makes something funny … and it isn't just images that trigger feelings … there's the music in the sound track … the sound effects … that make it abundantly clear … that it's meant to be funny and taken lightly … when you're watching a comedy … or that it's meant to be taken seriously when you're watching a drama … and it's a catalyst for memories … as you remember … things from your own experience that might relate to what you're watching … and if you're watching with someone else that keeps you connected to one another … the social side of watching a movie together … so there's images, sounds, feelings … reactions, memories … it's much, much more than just watching a movie … and what I'm drawing your attention to in a very deliberate way … is that how you view the experiences you go through each day … how you react to them … how connected you feel or how disconnected you feel … well it's not just your life … it's not just an event … there's so many different aspects … there's what actually happens … and there's your interpretation of what happens … the meaning that you give … to different experiences … and there are different components to each experience … what you notice and focus on … and isn't it interesting how some people focus on … the question of what's the most effective response to what's happening … and someone else focuses on the question of how does it make me feel … and someone else wants to focus on the component of … how it creates a choice for them of what to do next … and someone else focuses on … the uncertainty of what do I do now … and so it becomes very important … very important … to remind yourself … at any given moment … that you can actually choose which aspect of an experience to focus on … what the best response is … which is a different focus than how it makes you feel … what the most skillful way of handling something is … which is different than how it makes you react … and the more that you begin to focus yourself on regularly asking yourself the question … what's the best response here … what is going to … effectively empower you … by saying something clear … instead of getting upset … something that's going to demonstrate your power to choose … instead of reacting as if you have no choice but to be upset and anxious … should you focus inside or should you focus outside … and much more often than you ever realized before … the more that you focus outside … with the guideline of what works

best … in answering this person or handling this situation effectively … and if you think about the people who are effective people and high powered people … you watch them do that … the politicians in a debate … the CEOs of companies … who hold meetings in front of voters or stock holders … and someone in the audience will ask a pointed question … a critical question … and the person with finesse sidesteps the criticism … that's not the part they respond to … the part that they respond to is the opportunity to provide information … the opportunity to provide perspective … and so they sidestep the criticism … even though you can be quite sure … that inside … the criticism irritates them … but they take the opportunity to explain and to clarify … because that's what is more important in responding … and I can give you a thousand examples of that same kind of effective responding … a really good parent … whose child has just dome something wrong that angers them … or frustrates them because they were just so careless … and even though they have that initial surge of anger and want to … punish this child … they recognize that this is an important opportunity … to teach … and to teach in a way that's loving and patient … now not everyone has ideal parents like that … maybe you did or maybe you didn't … but the point I'm making … is that you can have … a flash of anger … a flash of fear … a flash of doubt … a flash of cynicism … pessimism … and what instantly begins to take hold of you is … the realization that that's not the part of you … that you want to respond from … and so you can set aside the anger or the fear or the frustration … and focus yourself intently … on providing an effective response … of what says what needs to be said … what explains and clarifies what needs to be explained and clarified … what needs to be taught and demonstrated … and when you grow more comfortable … with breaking situations down into their components … so that you're perfectly clear … that yes there's an emotional reaction … yes there's concern … or even fear … but what's more important … what you keep your focus on … is that there's something more important … than getting caught up in your feelings … the task at hand … matters more … and if you think about every movie you've ever seen where there was a hero … a hero that stayed focused on … the mission … the hero was afraid … you could see it … anyone could see it … the hero may even have said it … may have even gone through moments of self doubt … I can't do this … but it was the person's perseverance, tenacity … courage isn't about not feeling fear … courage is about staying focused on the goal … staying focused on the mission … and I say the mission … and that might make it sound much too important when all you're really trying to do is … teach a colleague or a friend … or a child … or a relative … how you want to be treated … what you want them to know about something … but all through each day you have an opportunity … to notice in the world around you … what's effective … what works … how people … achieve things … that they were motivated to achieve … even as they were scared to achieve them … and as you come to appreciate … that anxiety, concern, fear, worry … is only one part of you … and a part of you that's growing smaller and smaller day by day … as you grow stronger and more

focused … more oriented towards achieving your objective in each interaction … in each event … looking for the opportunities … looking for what can go right … to get across what matters to you … and so being able to appreciate every experience has many different components … what you're learning is a way of dividing and conquering … reducing concerns … as you focus on and amplify … in your awareness … what you want … a much greater source of power … focusing on what you do want … and when it becomes so clear to you … that … there are many, many more things to focus on of importance that will help you get done what you want to get done … I think you'll enjoy discovering … how much calmer … and more focused you are … remembering … this wonderful saying I learned a long time ago … that obstacles are what you see, when you take your eyes off the goal … and so you can be calm … and focused … and aware of the opportunities … to handle situations with skill … and purpose … Take some time to quietly absorb … these deep messages … and remind yourself many times throughout the day to focus on … which components of any experience … will best serve … your needs … in ways that will strengthen … and build your confidence … And then when you've had enough time for now … to process all these different ideas and possibilities … you can comfortably bring this session to a comfortable close … at a rate that's gradual and easy … and in a little while … when you're ready you can reorient yourself completely … bringing back with you that sense of knowing … knowing … and when you're ready you can reorient yourself completely, fully alert, fully refreshed, and that'll be the part to really focus on and enjoy.

The client was very deeply absorbed in the experience and took quite some time to reorient. She was quite thoughtful after reorienting and asked several poignant questions about why I thought she had developed her "give 'em both barrels" style. It led to a discussion about having grown up in a family where louder was better; where her three brothers would manipulate her if she didn't come at them full force to stop them. She realized this didn't fit well with what others were comfortable doing and resolved to "pause and speak only from the best parts of myself." In the last session, spaced a month later, she reported being proud of herself for "not only not blowing up even once, but being the kind of person I can finally respect."

CONCLUSION

Each of the seven transcripts included in this chapter was provided for the general purpose of illustrating what forms a hypnotic process might take. You may have noticed how each session was constructed according to characteristics of the individual client being treated. It is precisely for this reason that these transcripts are not likely to be useful to anyone else, even someone

with a similar problem, without considerable retailoring. Thus, the inability to standardize utilization approach interventions should be more readily apparent to you. Hopefully, though, your creativity is stimulated by thinking about what you might have said and done differently in working with such clients. There are lots of right ways to do clinical hypnosis, and it's the result you get that lets you know whether you were on the right track or not. An interesting or elaborate hypnotic process doesn't mean much if it doesn't generate the desired responses for you and your client.

FOR DISCUSSION

1. Do you think it would be useful to have a book of prepared scripts to use for specific client problems? Why or why not?
2. What do you think about the idea of common themes of human experience relative to therapy interventions?
3. Do you like learning from others' experiences? What limits, if any, are you aware of in employing metaphors as a teaching tool?

THINGS TO DO

1. For each transcript, identify the stages of induction, deepening, utilization, and disengagement. Do you see clear dividing lines between stages?
2. Identify the suggestion structures and styles in each of the sessions.
3. Find the places where metaphors, confusion, ambiguity, puns, and other such mechanisms are employed. How are they introduced and utilized?
4. Identify and list the most common (repetitive) themes in the client problems you encounter. What themes of therapy can you identify as relevant to treatment?

CHAPTER 23

WHEN PEOPLE RESPOND IN LESS THAN IDEAL WAYS

By now you have likely had many experiences of performing hypnotic inductions, facilitating hypnotic phenomena, and structuring and delivering suggestions to people during hypnosis that were meant to be helpful to them. As you have no doubt discovered from your direct experience, peoples' responses to your hypnotic processes can range from minimal to dramatic. You may now better appreciate why assessing hypnotizability has been the subject of serious inquiry as researchers and clinicians attempt to understand why people differ so widely in their abilities to respond to hypnotic procedures.

The main focus of this chapter concerns addressing these two related questions. First, how shall we interpret a lack of responsiveness to hypnotic suggestions, that is, when clients do not develop a particular suggested experience or, worse, give a negative response, such as irritation or distress? Second, how might we effectively respond to those individuals who are not particularly responsive to our hypnotic procedures?

These same questions apply to any form of intervention, of course, whether hypnosis is involved or not. Practitioners routinely assess the merits of their treatments, looking for evidence the treatment is or is not working to continually refine the treatment and how it is delivered. Psychotherapy, however, is not an exact science. Many different factors influence the outcomes, and many of these factors are subtle or even disguised. Thus, it is an ongoing challenge to evolve a way of looking at and responding to those cases where someone reacts poorly or not at all to your intervention.

Clinicians' responses to minimal or negative responses to their hypnotic suggestions have historically ranged from labeling unresponsive clients "resistant"

to labeling the clinicians providing the suggestions inept. These extreme views of either blaming clients or blaming the therapist reflect interesting explanations that reveal a pattern called *attributional style*, a person's characteristic way of explaining the meaning of life events (Seligman, 1989; Yapko, 1992, 2006a). An *internal* attribution is one that suggests the reason something happened the way it did is somehow "because of me." An *external* attribution says, in essence, that it happened the way it did "because of the other person" or "because of the circumstances."

In the realms of hypnosis and psychotherapy, the attributions that clinicians make for unsuccessful hypnosis sessions or therapies are often external; that is, it was the client's fault. Clinicians routinely say things like, "The person wasn't ready for change," "The person was getting too many secondary gains," "The person was too threatened by the therapy," and the ever-popular, especially in hypnosis, "The client isn't hypnotizable," or, "The client is resistant." Might any of these external attributions for a lack of client responsiveness be true at times? Yes. But might they also be blaming the client unfairly at times for what may be a limitation in the clinician's approach? Yes. I strongly encourage clinicians to recognize, before they reflexively declare a client resistant, that they may have played a bigger role in the client's responses than they may have realized. When there are two or more people in an interaction, there is a shared responsibility for the outcome. This point discourages entirely internal attributions as well, that is, "It's totally my fault the person reacted that way."

RESISTANCE IN HYPNOSIS

The literature pertaining to clinical hypnosis has generally had quite a lot to say about the issue of client resistance. Historically, resistance was considered to be a manifestation of the client's psychological defenses for coping with sensitive or unresolved intrapsychic conflicts, and thus perceived as a psychological vulnerability of the client's (Greenleaf, 2001). "Proper" treatment was a confrontive inquiry about the appearance of the resistance, first acknowledging it, next attempting to uncover its origin and function, and then collaborating on its resolution. Weitzenhoffer (2000) summarized this viewpoint succinctly when he wrote, "Unconscious resistance … always has its source in the psychodynamics of the subject, and overcoming or circumventing it is frequently dependent upon understanding these psychodynamics and acting accordingly.… At a conscious level, he may want hypnosis, but may be very much threatened by it at an unconscious level" (pp. 204–205).

From this perspective, resistance was always the client's creation. When it interfered with the progress of therapy, as it inevitably did, the client was blamed as the saboteur. Accusations and interpretations were thrust at the client who obviously "really didn't want to change" or perhaps was "too resistant to succeed."

Resistance can be described, for all intents and purposes, as a force that works against the aims of therapy. Resistance has long been recognized as an integral and unavoidable component of the therapeutic process, and virtually every therapeutic approach I am aware of has roughly equivalent recognitions of its existence. Only the rationale for its presence and the techniques for responding to it differ from approach to approach.

Describing resistance as a force that works against the aims of therapy doesn't place blame on either the clinician or client. Rather than view people who come in for help voluntarily (dealing with persons in treatment involuntarily differs in some ways) as not really wanting help when we try things that don't work very well, it seems much more practical to view resistance as a dynamic communication from clients about what they can and cannot do relative to the clinician's input (Zeig, 1980b). It can arise because the clinician's suggestions are inappropriate in some way (perhaps too complicated or too nonspecific) or because clients are dismissive of suggestions for a variety of reasons, such as when they already "know" nothing the clinician says can possibly help make a positive difference.

Placing this general perspective in the context of conducting clinical hypnosis, resistance is not necessarily an indication of unconscious sabotage on the part of the clients to be interpreted and corrected. It is frequently the case that clients are simply making a choice at some level not to respond in the desired way to suggestions for any of a variety of other reasons, each of which has a common denominator: the suggestion simply does not fit with the person's experience and, in fact, may even contradict it. Thus, resistance may be viewed as an interpersonal statement that says that whatever therapeutic strategies and maneuvers are being performed are not acceptable at some levels to the client.

Resistance is a real force to reckon with in treatment and can be tied to one or both of the two main areas of treatment: resistance to hypnosis; or resistance to therapeutic progress.

Resistance to Hypnosis

Undesirable responses to hypnosis can be manifested in a variety of ways. Clients may actively or passively refuse to go into hypnosis or may enter hypnosis but refuse to respond to the suggestions of the clinician. Examples of potentially contrary behaviors include but are not limited to: fidgeting, smiling, laughing, crying, interrupting, spontaneous disengagements, polar (opposite) responses, overcooperation, coughing, and direct or passive-aggressive hostility aimed at the clinician (Weitzenhoffer, 2000). Responses such as these are not necessarily resistant. They may be idiosyncratic responses that occur without interfering with the course of treatment.

Origins of resistance to hypnosis can be numerous. One of the most common is the fear of what will happen during hypnosis (Gibbons & Lynn, 2010).

If clients are misinformed about the nature of the hypnotic experience, they may fear it. All the misconceptions discussed in detail in Chapter 2 may be all that someone knows about hypnosis. If you thought you might divulge sensitive information, be coerced into doing things against your will, or be controlled by someone you really don't know much about, would *you* want to be hypnotized?

Resistance to hypnosis may also arise because of past failures associated with it, either from personal experience or the experience of credible others. Furthermore, resistance may also arise from negative feelings toward the clinician, thus highlighting the value of rapport, and from contextual variables such as the immediate environment, clients' mood, health, and even the weather (e.g., sinus headaches triggered by weather conditions).

At least some of the resistance to hypnosis, however, is attributable to the quality of the clinician's suggestions, specifically how well they match clients' experience. If I give clients a suggestion to feel their muscles relaxing and they aren't experiencing that sensation, then my suggestion does not fit with their experience and is easily rejected. To impose arbitrary suggestions on clients that they experience something you want them to experience, such as an arm levitation, that seemingly has little relationship to what they are experiencing or want to experience is a legitimate basis for them choosing not to follow your suggestion. Furthermore, your clients may be in so comfortable a state of mind and body that your suggestions for specific responses, simple as they may seem, are too much a strain for them to generate. Beyond that, your clients may be giving themselves suggestions that are more meaningful than yours. Why shouldn't clients be free to have that experience without being deemed "resistant"?

Hypnosis increases, rather than decreases, the range of individuals' self-control. Suggestions that don't fit well, by mismatching experience or by placing too much demand on them, can be and usually are rejected. A clinician can offer possibilities to clients and can then respond respectfully to the choices they make, utilizing them to further the aims of the therapy. To expect unquestioning obedience on the part of clients is wholly inappropriate in the clinical context, where collaboration in the service of therapeutic goals is vital.

Resistance to Therapeutic Progress

Resistance to the aims of therapy has an extensive overlap with the dynamics of resistance to hypnosis. Such resistance may be manifested by such contrary behaviors as appointments being missed, canceled, or arrived at tardily, assigned tasks ("homework") not being carried out, clock-watching, frequent interrupting and diverting from the topic, terminating treatment prematurely, overcooperation, inappropriate gift-giving, and requests for special favors.

Origins of resistance to the aims of treatment can be numerous. Blocks may arise because of clients' intrapsychic conflicts, that is, ambivalences, that have

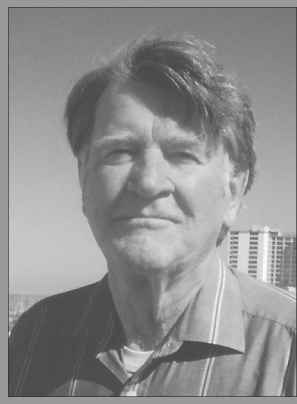
been described in detail in psychodynamic writings. They may arise because of the fear of change, since for many people change is considered a risky, scary process of giving up the known for the uncertainty of the unknown. Small changes can gradually give rise to big changes in one's life, and for many that is a frightening prospect. The reluctance to let go of the old, albeit dysfunctional, but familiar is a classic sign of resistance.

For this reason, the clinician, to intervene successfully, needs to understand the impact of clients' symptoms on their world. Symptoms can be viewed as a metaphor, or symbol, of their experience. They reflect limitations the individuals are experiencing in relating flexibly to the world around them. And symptoms have consequences: they affect clients' self-image, social network, behavioral possibilities, emotional realm, physiology, and spiritual makeup. Sometimes these consequences are deeply connected to the symptom's reason for being, and sometimes they're merely fallout. To attempt removal of a symptom without appreciating its role in the person's universe, though, is potentially hazardous. Symptoms may even serve protective functions at times, and clients' holding on to symptoms may look like resistance, but the resistance to the clinician's efforts is merely a side effect. Teaching better coping, that is, without symptoms, is obviously necessary and becomes a clearer therapeutic goal when the protective function of the symptom is understood.

Resistance to therapeutic progress may also be attributed to the type of intervention employed if it involves strategies and maneuvers that are unacceptable to clients. Furthermore, if the clinician is working at a faster or slower rate than clients, resistance can surface. Resistance may also arise from negative feelings toward the clinician, or their opposite—that is, idealized, romantic feelings that place a clinician on a pedestal he or she must inevitably fall from. Finally, contextual variables play a role as well, including such factors as environmental conditions, client disposition and health, and so forth. It should be apparent that all the sensitivity that goes into performing effective hypnosis is just a part of the larger therapeutic picture, for all the same guidelines apply.

Therapists were challenged to learn to think strategically about issues such as these by one of the founding fathers of strategic therapy, Jay Haley. In his classic 1973 book, *Uncommon Therapy*, Haley offered his insights into the nature of resistance when he wrote:

> When a person has a symptom, by definition he is indicating that he cannot help himself. His behavior is involuntary. The phobic or compulsive or alcoholic or disturbed family continue in ways that bring distress while protesting that they cannot help behaving as they do. In the same way, the subject who volunteers for hypnosis will often not follow a directive. He does not refuse; he merely indicates that he is unable to. Or he will respond in a contrary way, while indicating that he is not causing this to happen.… The art of hypnosis is to deal with this kind of resistance and bring about change, and so too is the art of therapy the effective solution of this kind of problem. (p. 24)



FRAME OF REFERENCE: JAY HALEY

Jay Haley (1923–2007) was one of the most influential figures in the field of psychotherapy and is recognized as such by all those who have had even just a passing interest in hypnosis, systems theory, family therapy, and strategic psychotherapy. His contributions to the clinical world are profound in helping us to understand problems in interpersonal terms and in stressing the need to intervene actively and strategically for our clients' benefit.

Mr. Haley wrote nearly two dozen books on therapy, including *Strategies of Psychotherapy* (1963), *The Power Tactics of Jesus Christ and Other Essays* (2005), and perhaps his most well-known work, *Uncommon Therapy: The Psychiatric Techniques of Milton H. Erickson, M.D.* (1973). He also edited *Advanced Techniques of Hypnosis and Therapy: Selected Papers of Milton H. Erickson, M.D.* (1967). It was these latter books that rocketed the innovative nature of Milton Erickson's strategic approaches into the forefront of systemic thinking and simultaneously revealed the crispness and incisiveness of Mr. Haley's thinking about the complex process of psychotherapy. It remains "must" reading for clinicians. Mr. Haley was a long-time friend and mentor, and in one recent discussion shortly before he passed away I mentioned to him that I still read *Uncommon Therapy* each year just to remind myself what therapeutic genius is all about. He paused before he quipped, "I think everyone should read *Uncommon Therapy* every year … and buy a new copy each time." His wit was one of his many endearing traits.

Mr. Haley's work continued even in his "retirement," as he and his wife, the anthropologist and filmmaker Madeleine Richeport-Haley, worked on producing training videos on therapy. Recently, Dr. Richeport-Haley and her colleague, psychologist Jon Carlson, assembled a collection of Mr. Haley's seminal articles and had experts write introductions and commentaries to them. The volume is called *Jay Haley Revisited* (2010), and it provides a superb overview of Mr. Haley's many contributions to the fields of hypnosis and psychotherapy.

Mr. Haley was cofounder of the Family Therapy Institute of Washington, D.C., research associate at Stanford University and the Mental Research Institute, and founding editor of Family Process. He is the first recipient of the Lifetime Achievement Award of the Milton H. Erickson Foundation, which also held a Festschrift in his honor in 1999. The many papers and accolades offered in Mr. Haley's honor were published in a 2001 volume edited by Jeffrey Zeig called *Changing Directives: The Strategic Therapy of Jay Haley.* In recognition of his lifelong contributions to humankind, Mr. Haley was awarded an honorary doctorate in June 2002 by Alliant International University in San Diego. Mr. Haley's papers and other materials are now archived in the Department of Special Collections at Stanford University.

Mr. Haley was a modest man with some strong opinions. His dry wit and ability to sense and articulate the ironies of the therapy business are simply unparalleled.

On types of hypnosis: "I tend to think of three different hypnoses: (1) the personal hypnosis, where you go through a yoga experience or meditation experience, or whatever; (2) research hypnosis, where you're trying to find the limits of influence of hypnosis in various ways—in terms of deafness, color-blindness, or whatever; and, (3) clinical hypnosis, where you're trying to change someone—and I don't think that has anything to do with the other two hypnoses.… It's so different changing someone; the person's motivation is different, the responses are different."[2]

On hypnosis and double-binds: "In hypnosis we found the first double-bind. (Gregory) Bateson had this idea of the double-bind, but we couldn't find one. And I remember when I realized that a hypnotist was directing a person to behave spontaneously—that was the double-bind, a classical paradoxical conflict."[2]

On defining problems in social terms: "I think a lot happened in the 1950s. Therapy became more social and began to change and transform. Things are still changing, and we are still exploring. I think the most important idea that came in this [20th] century was that the individual wasn't the appropriate unit of study; rather it's the individual and others together. As Gregory Bateson said, 'The mind is outside the person.'"[3]

On defining problems in biological terms: "I'm not an enthusiast for attributing so much to an individual's biochemistry. I think that is important for certain problems, but I think that the overselling of medications is one of the worst problems in the field, and it is getting worse all the time. Some psychiatrists now don't even seem able to talk to people—they only listen to decide which medications to prescribe. It's a shame."[3]

On family therapy today: "I think the state of family therapy is still developing, but it still has a number of people trying to haul it back into an individual theory. I think the problem is that most teachers are still trained in doing individual therapy and they try to draft the theories of family therapy to fit an individual model."[3]

On the diversity of therapies: "I think we have been too lenient in many ways. One of the problems is that there is no longer any orthodoxy in the field. When

there is no orthodoxy, you can't be a deviant. So, what used to be condemned as deviance years ago is not being condemned now. If they do something a little different in therapy, they immediately form a school with powers of influence rather than saying it is just one more technique that a therapist should be able to use when necessary."[3]

On "impossible" cases: "Well, I can't think of one—certainly not on the basis of any category, because the category isn't the person. And you're dealing with the person—not a set of ideas.… If you're a competent therapist, you're going to win some and lose some. It doesn't mean they're incurable; it just means you haven't found a way to cure them."[2]

On his most significant contribution: "I think my most significant contribution is breaking therapy down to a practice of specific skills—of simple ideas, skills, and techniques. This is quite different from the nondirective ideology the field had when I first got into it."[3]

[1] *Full transcripts of Michael Yapko's interviews with Jay Haley are published in* Changing Directives: The Strategic Therapy of Jay Haley *(Zeig, 2001).*
[2] *Personal communication, December 9, 1988.*
[3] *Personal communication, January 15, 1999.*

Haley (1973) offered a variety of ingenious methods for responding to resistance, including (1) encouraging resistance; (2) providing a worse alternative; (3) using indirection, especially metaphor; (4) encouraging a relapse; (5) encouraging a response by frustrating it; (6) avoiding self-exploration; and (7) amplifying a deviation from the usual dysfunctional pattern, that is, building on small steps that move in the right direction. Some of these are described in detail later in this chapter. Haley's brilliance in generating effective strategies of psychotherapy has guided the training of generations of therapists.

RESPONDING TO RESISTANCE

How to deal with communication deemed "resistant" is, of course, a function of how you conceptualize it. How you define resistance and to whom you reflexively assign responsibility for it will determine whether you tend to view resistance as a property of the client, a property of the clinician, or an interactional outcome of the two. Listed in Table 23.1 are some of the many ways to respond to resistance.

Accepting resistance as a valid communication from clients paves the way to elevate the relationship to a new level of collaboration through what Milton Erickson called the *utilization of resistance* (Erickson & Rossi, 1979; Erickson, Rossi, & Rossi, 1976). Erickson's unique perspective on resistance makes a great deal of sense. Better yet, it works by diffusing and redirecting people's resistance to hypnosis and therapy.

Table 23.1
Potential Responses to Resistance

1. Ignore	8. Intersperse
2. Examine	9. Deflect
3. Encourage	10. Diffuse
4. Prescribe	11. Confront
5. Confuse	12. Redefine
6. Dissociate	13. Interpret
7. Associate	

The basic utilization formula of accept and utilize applies here. In practice, it takes the form of being able to skillfully accept clients' response as a valid one while developing a way to utilize the response in service of further suggestions. For example, if Erickson was performing an arm levitation on someone, offering suggestions for her arm becoming lighter and lighter, but she reported experiencing her arm as getting heavier and heavier, Erickson would say something like, "That's right, that's fine, and your arm can get heavier still." By accepting clients' response as a valid one, it can be built upon, redefining a seemingly resistant behavior as a cooperative behavior. If the goal was to get an arm levitation, that is, a sensory alteration in the person's arm, then a "heavy arm" is an acceptable alternative in the same realm of response. It just wasn't a compliant one with the clinician's arbitrary demand for a levitation. If the clinician is able to redefine clients' behavior or perceptions as cooperative, then where is the resistance? Finding a way to make the nonconforming behavior seem an asset to individuals can also change the feeling they have attached to it in favorable ways (Gilligan, 1987).

Another technique for managing resistance is more preventive: *employing process suggestions*, that is, suggestions without specific content. By not asking for a specific response and then covering all the possible responses, whatever clients do is defined as cooperative. For example:

> You can notice the temperature in one of your hands, and as you continue to breathe in and out at your own comfortable rate, you may notice how your hand becomes warmer, or perhaps cooler, or you may notice how the temperature remains the same …

The person's hand is going to either get warmer, cooler, or stay the same. What other possibilities are there? Therefore, any response clients generate can be accepted and utilized as a cooperative one.

Erickson was of the belief that clients need to be able to resist directives to maintain a sense of autonomy rather than adopting a position of mere obedience to authority (Erickson & Rossi, 1979; Zeig, 1980). Thus, one of the

strategies he often employed was offering clients multiple directives simultaneously so that they could resist one and accept the others. For example, I may direct a client to, "Sit down, close your eyes, uncross your legs, take a deep breath, focus on my voice, and remember an experience from childhood you can talk about." By offering so many directives at the same time, the probability is I will get most or all of the desired responses. Even if clients resist one, I will have gotten the other responses and can resuggest the resisted one in a different form later if I care to.

Notice also in the previous suggestions the phrase "… an experience … you can talk about." The implication to clients is that they can refuse to talk about some experiences, allowing them to resist telling me something while simultaneously following my guidelines.

Another technique for managing resistance is the strategy Jay Haley (1973) described as *encouraging resistance*. When you encourage resistance, usually with an intentional use of negative suggestions, for clients to resist resisting, they must cooperate. It's a kind of *reverse psychology*. For example, if I'd like the client to sit down but anticipate that a straightforward directive to do so will be met with resistance, instead I can suggest, "You don't have to (*pause) sit down. I don't expect you can make yourself comfortable (embedded command) he*re. It will be much better for you to stand just as you are."

By encouraging him to resist sitting and remain standing, his resistance to me can now allow him to be seated. Either way, sitting or standing, his behavior is defined as cooperative: sitting is what I want him to do; standing is what I've directed him to do.

Acceptance and Flexibility Are Key

Responding to clients' resistances in a way that is accepting and nonconfrontational requires considerable flexibility and respect for their integrity. Flexibility refers to the ability to have a variety of ways to get a point across without having to beat clients over the head with it. Flexibility means being willing to go the extra distance to meet clients on their level, joining their reality instead of expecting or demanding them to come to yours. It also means not having so rigid a set of expectations and procedures that your approach wouldn't allow for unique, individual responses. You can see a sharp division on this point between different schools of hypnosis, given how some approaches emphasize the importance of invariant procedures as a means of assessing client differences.

It is important not to build resistance in your client by doing things the way you think they should be done with little or no regard for their expectations, beliefs, values, and unique talents. If you attempt a strategy that fails or offer a suggestion that is responded to unfavorably, don't do the same thing over

again a little more emphatically. Instead, shift your approach smoothly, and perhaps even compliment clients' resistance if you care to comment on their ability to make effective choices on their behalf. Then do something different.

Not many people like to be told exactly what to do, so commanding individuals to respond obediently, as in direct authoritarian suggestions ("You will do this"), generally encourages resistance. A helpful guideline is this: the more resistance you anticipate getting or actually derive from clients, the greater the need for permissiveness and even indirection in your approach. As Jeffrey Zeig (Zeig, 1980; Zeig & Rennick, 1991) pointed out, if clients are obedient and highly responsive, the use of indirect techniques isn't really necessary. But when you have individuals who are wary or uncomfortable with hypnosis or therapy or simply aren't very cooperative for whatever reason, then permissiveness and indirection become invaluable mechanisms for attaining increased responsiveness.

CONCLUSION

Resistance to change seems to be a basic feature of humankind. We spend so much of our lives trying to build a ritualized pattern of behavior so as to expend the least amount of physical and mental energy, and then after developing such a pattern we frequently complain of "being stuck in a rut."

Resistance doesn't always show up in detectable ways, and resistance can't always be used in the service of change. Some clients simply will not change, others only slightly. The discussion of resistance in this chapter suggested that the resistance that has usually been thought of as intrapersonal may actually be interpersonal, arising from a demanding or somehow incompatible approach to clients. Interventions have a better chance of succeeding when you are able to flexibly get a single point across in a number of different ways, using the feedback from each unique individual you treat to adapt your methods accordingly.

FOR DISCUSSION

1. What personal changes would you like to make that you have had difficulty changing thus far? How would you react to someone who suggested to you that you must not really want to change it or else you already would have? Do you believe "where there's a will, there's a way?" What resistances to change can you identify as underlying your inability to change thus far?

2. What reasons can you suggest for why people both seek change and avoid it?
3. Can all people change whatever trait they wish to, or are some aspects of people unchangeable? Why or why not? How does your belief in response to this question influence your work?
4. How might resistance be a reflection of one's limitations?
5. What examples can you cite for how people work to get into a predictable pattern and then complain about "being in a rut?" When is a predictable pattern an asset? A liability?

THINGS TO DO

1. In a "hand dance" exercise with your study partner, sit opposite each other, eyes closed, and hands held up to each other as if to play patty-cake. Silently, one will begin to move his or her hands in all directions with the other person following, all the while keeping your hands together with your partner's. When a minute or so has gone by, switch so the other person leads the hand dance. What feelings come up as you lead and follow? Did you experience resistance? Why?
2. Research ways resistance has been considered over the years. Who gets blamed for it? How is it treated?
3. Go through the list in Table 23.1 of possible ways to respond to resistance and generate a suggestion for each one.

CHAPTER 24

HYPNOSIS WITH CHILDREN AND ADOLESCENTS

> Children have a driving need to learn and to discover, and every stimulus constitutes, for them, a possible opportunity to respond in some new way … hypnosis offers to the child a new and ready area of exploration.
>
> **Milton H. Erickson (1958/1980, p. 174)**

Clinicians are generally motivated to alleviate human suffering. It's "the calling" we receive from somewhere deep inside that compels us to devote huge portions of our lives to striving to make a meaningful difference in the lives of others. It leads us to spend many years going through formal academic training and countless hours of studying and practicing so that when our skills are put to the test with someone in distress asking for our help, we can say and do something substantive to help. There is something even more urgent about alleviating someone's suffering when that someone happens to be a child. Children seem to inspire a sense of protectiveness in most people, probably because of their seemingly greater vulnerability and innocence. Their suffering especially drives many health-care professionals to want to help. For many pediatric specialists, hypnosis has become a principal tool in that worthy endeavor.

In this chapter, we will explore the use of hypnosis with young people. Can hypnosis be successfully applied with children and adolescents? If so, are there any special considerations for utilizing hypnosis with younger clients? What kinds of problems might hypnosis be used to help treat?

CHILDHOOD IS NOT NECESSARILY A GOOD JOB FOR THE YOUNG

Every generation has had to face its fair share of stressors, and each age cohort shares a connection to the common cultural forces shaping its development. Whether it was growing up in the Great Depression or in the hippie era of "flower power" or the current age of living (too) much of daily life electronically, the inevitable forces of socialization leave an indelible mark on each of us. These come primarily from the larger society of which we are a part and from the family in which we are raised. The experiences we are and are not exposed to, the values we are and are not encouraged to adopt, the skills we are encouraged to develop and, likewise, dissuaded from developing, and the perspectives we are taught to absorb are all powerful in shaping how we live. This process of socialization begins quite literally at the moment of birth. Some would suggest it begins even earlier.

While every generation has had stressors to cope with, the evidence is substantial and growing that our young people are facing a variety of stressors that are harsher, more complex, and more frequent. Kids face things now that their parents never did, from cyber-bullying to having to walk through metal detectors to go to school. Where and how do they learn the skills for coping with the power and invasiveness of technology, the brute force of the media, the omnipresent electronic eyes that can capture and instantly post online their most embarrassing or painful moments for the amusement of others, the preoccupied parents that are too busy to notice much less help with the ongoing challenges of life, or worse, contribute to them through bad behavior or indifference. It *is* tougher to be a kid today.

These challenges are merely the ones posed by a fast-paced and sometimes thoughtless culture. What about the challenges of "just" growing up: learning how to think and how to learn, how to recognize and manage your feelings, how to evolve a self-awareness and self-acceptance for your unique attributes, how to learn and take care of your body's needs, how to conduct yourself with others and meet your social needs, discovering your sexuality and how and when to express it, discovering and developing your talents, setting and protecting your boundaries, and on and on? Add to this the additional burdens of having to cope with acute or chronic illness, unexplained symptoms, injury, loss, rejection, disappointment, humiliation, self-doubt, and the many other inevitable adversities in life. It is tough to be a kid *any* day.

It's important for every clinician, whether utilizing hypnosis or not, to appreciate not only individual children and their concerns but also the larger social context in which these concerns arise. Although it's a tough job being young, an aware clinician can do much to make the job easier. Hypnosis can play a pivotal role in helping empower kids to evolve the skills in effective

problem solving and healthy coping that foster a greater sense of mastery that can endure a lifetime.

WHY USE HYPNOSIS WITH CHILDREN?

Given the many challenges of childhood, how can we best prepare a child to meet and, hopefully, transcend them? As parents, we know we can't prevent our children from facing the challenges of life: no matter how much we love them, we can't prevent them from catching the flu, falling off a bicycle, failing to make the team, being teased by other kids, and the many other much worse things that happen in normal lives that simply can't be controlled. We can't carry all the responsibilities for what happens to our kids even if we desperately try: if you break your leg, no matter how much I might love you, you're still the one who has to wear the cast. Even if we could control circumstances and prevent adversity from affecting our children, then we inadvertently create a new problem in doing so: we leave them woefully unprepared for how to skillfully manage and bounce back from adversity.

There are skills, however, that can make growing up easier. Not easy, necessarily, but easier. Pause for a moment and think about what some of those skills might be. Most certainly on the list are good social skills, good problem-solving skills, impulse control, frustration tolerance, positive coping and self-soothing skills, and appropriate support-seeking, to name just a few. A great variety of such skills have collectively been called *emotional intelligence* (Goleman, 1995) and *social intelligence* (Goleman, 2006). Without exaggeration, these intelligences encompass many of the key skills that can be taught early on in children's lives that can make a lifetime of difference in terms of happiness and success. Positive psychology has also made great and still growing contributions to our understandings of what fosters resiliency and promotes character strengths and virtues in our children (Moore & Lippman, 2005; Seligman, 1995).

What role might hypnosis play with children? When you consider the extraordinary amount of ongoing learning and growing that children engage in, we want to structure learning opportunities in ways that engage and empower them. Hypnosis is ideal for these purposes. I appreciate the perspective provided by psychologist William Wester II and pediatrician Laurence Sugarman in their book *Therapeutic Hypnosis With Children and Adolescents* (2007):

> Children are developmentally in motion both physiologically and psychologically. They live in a land of discovery where ideas realize themselves and imagination prevails … In our therapeutic encounters with them, our goal is to interact with this on-going process, go with the flow and the child, and begin a journey of allowing children to do whatever is

> necessary to heal themselves … We offer them guidance and confidence while having fun, being playful, and watching them develop their capacities for resilience. (pp. xi–xii)

Hypnosis has been used successfully in treating a broad array of children's problems, as we will see later, primarily by acknowledging their individuality and tapping into their innate drive toward growth and mastery. Working with children, with or without hypnosis, requires a more specialized skill set, however. Many developmental factors influence their responsiveness to treatment. Hypnosis, with its emphasis on recognizing and utilizing the uniqueness of each person, provides a strong but flexible framework especially well suited for meaningful interventions with children.

DOES AGE INFLUENCE HYPNOTIC RESPONSIVENESS?

The use of hypnosis with children has directly been described in the literature since the time of Mesmer (in the late 1700s), Charcot, and Bernheim (in the late 1800s). The topic was addressed by many early writers in the field, including Sigmund Freud, William Kroger, and Milton Erickson. These writings were insightful and informative but were entirely impressionistic. It wasn't until the middle of the 20th century that serious research began to consider how hypnotic responsiveness might be related to one's age and how that might affect hypnotically based clinical interventions. Even now, despite there being a sizeable literature describing the efficacy of pediatric applications of hypnosis in clinical reports and small, uncontrolled group studies, the literature describing controlled research on the use of hypnosis with children in adequate sample sizes continues to be underdeveloped (Gold, Kant, Belmont, & Butler, 2007; Milling & Constantino, 2000; Rhue, 2004).

With the development of standardized scales, such as the Stanford Hypnotic Susceptibility Scales (SHSS:A, SHSS:B, and SHSS:C) and its derivatives, including the Children's Hypnotic Susceptibility Scale (CHSS; London, 1962, 1963) and the clinically oriented Stanford Hypnotic Clinical Scale for Children (SHCS:C; Morgan & Hilgard, 1978–9), varying responses across individuals to standardized inductions were considered valid and reliable indicators of hypnotizability. Thus, it became possible to test different populations, perhaps according to gender, symptom profile, or age.

Research using these scales has generated a high degree of consistency in these key findings. First, children appear to be more hypnotizable than adults (Morgan & Hilgard, 1973; Weitzenhoffer, 2000). Second, children under age 3 show little testable hypnotic ability, and age 4 is considered the youngest testable age (Rhue, 2004, 2010). Third, hypnotic ability increases throughout early and middle childhood, reaching its peak around the ages of 12, then plateaus for a couple of years, decreases slightly during adolescence,

then remains stable into adulthood (Rhue, 2004, 2010). Morgan and Hilgard (1973) reported a decrease in hypnotic ability after age 36. In a recent study by Page and Green (2007), using the Harvard Group Hypnotic Susceptibility Scale (HGSHS:A), they reported a similar finding of a small magnitude decrease in scores across the ages of 17 to 40 but a slight increase after that. Their study did not include children.

What do these studies relating age to hypnotizability scores on standardized tests really mean? The answer, of course, will depend on at least these two factors: (1) how valuable you consider standardized test scores to be; and (2) how much credence you give to group profiles as they relate to individuals within that group. If children are more hypnotizable, does that apply to all children?

The generalizations about children abound in the literature. William Kroger (2008) wrote, "Children over 5 years of age have the necessary verbal understanding to be hypnotized" (p. 281). Milton Erickson (1958/1980) wrote, "The limited experiential background of the child, the hunger for new experiences, and the openness to new learnings render the children good hypnotic subjects. They are willing to receive ideas, they enjoy responding to them—there is only the need of presenting those ideas in a manner comprehensible to them" (p. 174). Such broad observations may be valuable in a general sense but may or may not apply to any one individual, limiting their clinical usefulness. We will explore shortly how to engage with the individual child-client.

Perhaps surprisingly, given his long-term commitment to developing the standardized test considered the premier test for hypnotizability, the Stanford Hypnotic Susceptibility Scales, André Weitzenhoffer was clear on the limitations of group profiles. He was a harsh critic of studies of hypnotizability based on membership in some demographic or clinical group:

> Some of these studies involving individual differences have been guided by the existence of a hypothesis or theory. Others have been side-products of a study looking at some other feature.… Still others have been more of a stab in the dark in the hope of finding something, anything. With few exceptions … the data on individual differences has contributed little to nothing to our understanding, production or use of hypnosuggested behavior. (2000, p. 281)

Simply put, if the level of consideration is individual clients, then the generalizations that suggest which age group is more or less hypnotizable in response to some standardized test become irrelevant. Pediatricians Dan Kohen and Karen Olness (2011, p. 426) stated unequivocally in their superb text, *Hypnosis and Hypnotherapy With Children*, "The existing scales do not allow predictions about which children might be most successful in the therapeutic application of hypnosis." Even with very young children, deemed unhypnotizable by some experts, it is interesting to note, as Rhue (2004) did, that there have been many reports of successful therapeutic outcomes utilizing hypnosis

with preschool children, including resolution of such issues as enuresis and encopresis. Rhue suggested, "These may be children who can use their skills in daydreaming, fantasy and imaginative involvement to respond to direct or indirect suggestions" (pp. 120–121). These capacities seem to have the greatest relevance to hypnotic responsiveness in children. Thus, it is reasonable to take the position that age matters less than the child's capabilities, as Kohen and Olness (2011) pointed out.

STRUCTURING AGE-APPROPRIATE SUGGESTIONS IS BASED ON A KNOWLEDGE OF CHILD DEVELOPMENT

Since hypnotizability testing is of limited value as a predictor of clinical response in both children and adults, the task of the clinician remains the same across all therapeutic interactions: build a therapeutic context, especially the relationship with the client, that makes effective treatment possible. It begins with the acknowledgment that a child's experience, including style of thinking and processing information, style of communicating, and style of relating are different from an adult's. As Barabasz and Watkins (2005) pointed out:

> Unique treatment approaches are called for when treating the problems of childhood. Sophisticated verbal psychotherapies can be of little use when dealing with the immature cognitive processes and emotions of the developing child.… Failures in treating them often stem from the fact that the therapist does not reason like the child does. Therapists … must be able to gear their thinking and feeling modalities to the level of the little patients if success is to be achieved. (pp. 387–388)

Milton Erickson (1958/1980) made the same point more descriptively:

> Pediatric hypnotherapy is no more than hypnotherapy directed to the child with full cognizance of the fact that children are small, young people. As such, they view the world and its events in a different way than does the adult, and their experiential understandings are limited and quite different from those of the adult. Therefore, not the therapy but only the manner of administering it differs. (p. 174)

Dan Kohen, MD, is internationally recognized as a leading expert in pediatric hypnosis. He is director of the Behavioral Pediatrics Program at the University of Minnesota as well as codirector, with Dr. Pamela Kaiser, of the National Pediatric Hypnosis Training Institute (NPHTI), the principal national organization in America for training professionals interested in learning to apply hypnosis with young people. Asked what special considerations are required in doing hypnosis with children, his immediate and forceful answer was "an in-depth knowledge of child development. If someone is going to

work with children with hypnosis, they better understand child development first. Two-year-olds are not the same as infants and not the same as kids who are 7 or 12 or 14" (personal communication, June 10, 2010). Kohen's advice is, of course, sound. Offering children suggestions that are behind or ahead of their developmental capacities is an obvious formula for failure: "For example, if you're going to talk about conscience with a 9-year-old, you're going to get nowhere. They don't get it. It's not [typically] the way they think" (personal communication, June 10, 2010). A fine chapter by Kuttner and Catchpole (2007) further elucidated the issue of developmental considerations in using hypnosis with children.

Thus, the same points about conducting good therapy in general readily apply, from responding to individuals (including their developmental level) rather than a diagnostic label to looking for strengths and associated opportunities to enhance a sense of mastery to hypnotically creating a context for teaching new skills and introducing generative perceptual shifts. Kohen and Olness (2011) captured the attitude of good therapy with children:

> In our therapeutic work, we recognize that we are not treating problems; we are treating and helping children who happen to have problems. No matter how severe the problems of our child patients, we address ourselves to their striving for experience, for mastery, for social interaction, for the inner world of imagination, and for wellness. Thus, we gain an ally in that part of the child that wants to experience life to the fullest, and this alliance forms the foundation of treatment. (p. 5)

Knowing that the world of children is different from the world of adults requires an ability on the part of the clinician to set aside his or her adult frame of reference. This is typically easier said than done. Erickson (1958/1980) had some direct advice on this issue: "There should not be a talking down to the child, but rather a utilization of language, concepts, ideas and word pictures meaningful to children in terms of their own learnings" (p. 176).

Kohen suggests assessing children on a number of specific criteria: their cognitive ability, level of emotional development, degree of social development, and level of intellectual development. As an example, Kohen described how a child of 5 or 6 suffering with primary nocturnal enuresis (i.e., bedwetting at night) is unlikely to grasp the concept of *future*. To a child of 5 or 6, "the future is tomorrow, or tonight. You talk about having a dry bed tonight, waking up tomorrow in a dry bed" (personal communication, June 10, 2010).

A realistic approach to children comes about from studying and learning about children and their development. Based on that information, then, a clinician can design an age-appropriate treatment. Thus, it helps to have an organizing framework for how to interview children, to establish a therapeutic alliance, and to utilize that alliance as a primary force driving the therapy forward. Diane Yapko, author of *Understanding Autism Spectrum Disorders:*

Frequently Asked Questions (2003), is a pediatric speech-language pathologist who specializes in treating children on the autism spectrum. (She's also my wife.) In a chapter regarding autism and depression, she offered a series of questions to help organize the clinician's approach to children:

> A clinician must ask him or herself several questions: (a) what goal is to be accomplished, (b) how might the session's goal best be achieved with this particular individual, (c) what strengths and interests (e.g., personal resources) does this client have that would be appropriate and helpful to utilize, (d) what deficits might this person have that may interfere with utilizing a particular strategy, and (e) how much attentional focus and concentration does this client have at this time? (2006, p. 261)

The answers to each of these questions can be derived only from careful observation and attentiveness to children, noticing and acknowledging their unique attributes. Some of these attributes relate to patterns of self-organization (e.g., attributional style, cognitive style, relational style, attentional style), and some of these attributes reflect personal lifestyle, encompassing preferences for specific interests, hobbies, people, places, and so forth.

As with adults, children, especially older children, often know what they want (e.g., "I want my parents to get off my back") but not how to obtain it. The more globally people of any age define a goal (e.g., "I just want to feel good"), the less likely they are to reach it. Thus, Yapko's questions above (2006, p. 261) become especially important in helping move from a global to a more detailed and age-appropriate intervention. Increasing children's sense of mastery in some area doesn't happen through global interventions that suggest, for example, "as you get older you'll improve." Rather, the primary task of the clinician is to help build a bridge between where children are now and where they want to be. Identifying and developing the steps children can follow and gently encouraging taking those steps is pivotal to cocreating the therapeutic context. Identifying the resources that can help facilitate this process is what makes the treatment personal, compelling, and more likely to succeed.

ENGAGING WITH THE CHILD-CLIENT AND ESTABLISHING THE THERAPEUTIC CONTEXT

Kohen has a deceptively simple approach he often uses with kids, typically opening up the interaction by asking, "How come you came here?" He said, "Kids know why they've come to the doctor. I just want to find out what they already know." He prefers this kind of spontaneous intake to receiving parental reports first that might bias his clinical impressions.

FRAME OF REFERENCE: KAREN OLNESS

Karen Olness (1936–) is professor of pediatrics, family medicine, and international health at Case Western Reserve University. She is also director of Rainbow Center for International Child Health. Dr. Olness has specialized in pediatric medicine since receiving her medical degree from the University of Minnesota in 1961. Actually, she chose her specialty much earlier, first declaring at age 6 that she wanted to be a doctor. Later, at age 12 she wrote an essay titled "Why I Want to Be a Pediatrician." Her dedication to the needs of children has been extraordinary, serving as president of the Northwestern Pediatric Society and as president of the Society for Developmental and Behavioral Pediatrics.

Dr. Olness has had a long-time interest in clinical hypnosis, and her work in the field has been highly visible and influential, especially through her classic text *Hypnosis and Hypnotherapy With Children*, now in its 4th edition and coauthored with pediatrician Kohen (Kohen & Olness, 2011). She is also the author of more than 50 articles and nearly two dozen book chapters. She is past president of the International Society of Hypnosis and of the American Society of Clinical Hypnosis (ASCH), the Society for Clinical and Experimental Hypnosis (SCEH), and the American Board of Medical Hypnosis. Dr. Olness is exceptionally knowledgeable about the applications of hypnosis with children.

Even more remarkable than her many professional accomplishments are her many humanitarian contributions. Dr. Olness is medical director and cofounder of Health Frontiers, a volunteer faculty outreach in international child health. Through Health Frontiers and other humanitarian organizations (such as the International Rescue Committee) she has helped set up a pediatric residency program in Laos, helped support HIV research in Uganda, consulted to faculty in Turkey regarding the effects of earthquakes on children, helped in Albania with

Kosovo refugees, helped in El Salvador with hurricane survivors, and helped refugees in Rwanda and Afghanistan. She brings a strength and kindness to the field that is exceedingly rare and precious.

Dr. Olness has been recognized for her remarkable efforts with many honors and awards. She has received the Outstanding Physician Award from the Minnesota Association of Women in Medicine, the Aldrich and Christopherson Awards from the American Academy of Pediatrics, and the Distinguished Service Award from the International Health Medical Education Consortium. Recently, Dr. Olness was elected to the Cleveland Medical Hall of Fame and was named one of the Distinguished Women in Health Care in Cleveland. She also received the Benjamin Franklin Gold Medal from the International Society of Hypnosis, its highest award, in 2009. She may belong to Cleveland, but she is world-class.

On how the field of hypnosis has changed since the late '60s, when she began using hypnosis: "I think that induction techniques are less authoritative. It is encouraging that there has been substantial research to document physiological changes (including brain changes) and mechanisms associated with hypnosis. In spite of this, there do not seem to be greater numbers of health professionals who study or use hypnosis. For example, membership in both the ASCH and the SCEH is substantially less than 20 years ago. On the other hand, some other professional organizations have developed regular hypnosis workshops, and there are more articles about hypnosis published in nonhypnosis journals. Nurses are using hypnosis in increasing numbers and doing a great deal of research using hypnosis; however, they call hypnosis guided imagery or visualization."[1]

On what any student new to the field of hypnosis should know about doing hypnosis with children: "It is fun to work with children. It is also a joy to give them the gift of self-hypnosis and to follow them over years. I now hear from adults in their twenties and thirties who still use their self-regulation skills, acquired when they were young children. I believe that all children with chronic conditions such as hemophilia, cancer, diabetes, and sickle cell disease should have the opportunity to learn self-hypnosis as soon as possible after the diagnosis is established."[1]

On implications of her research in which schoolchildren used self-hypnosis to change immune responses, including both humoral and cellular responses: "Dr. Hewson Bower in Australia repeated our work and took it into the clinical realm. Her carefully done thesis demonstrated that children who learn and practice self-hypnosis have reduced numbers of respiratory infections, and fewer days of illness when they do contract a respiratory infection. There is substantial evidence that various stressors suppress immune responses. It would seem a good idea to teach all children how to use self-hypnosis to cope with stress."[2]

On how average children can use hypnosis to change the temperature in their fingertips or their electrodermal activity: "There are now many monitoring

systems, ranging from a bioband that cost a few dollars to biofeedback units costing thousands of dollars. Both children and adults enjoy seeing graphic evidence of their ability to control body responses. In general, I use a biofeedback monitor when teaching children self-hypnosis, as an adjunct, to encourage them to recognize their own self-control."[1]

On the evolution of her "mind–body machine" for children: "I had long had the idea that it would be helpful if there could be an easy way to give young children an experience which would make it clear that 'thinking changes body responses.' Ten years ago we developed a touchscreen computer program driven by a sensor that measures galvanic skin resistance. This unit was in the Cleveland Health Museum until just recently when the museum closed for major renovations. Thousands of schoolchildren responded to the instructions for using this program. Basically, they can choose a favorite animal on the screen. As they follow instructions to imagine themselves in a safe, favorite place, the animal will smile. My computer engineer colleague has now modified the program so it is available on a CD-ROM for home computers. I have one of these programs on a laptop and use it frequently in the clinic and hospital."[1]

On how hypnosis can help children with depression: "Teaching children self-hypnosis can facilitate a sense of self-control and mastery, which is important for depressed children. Often children who are depressed also have depressed parents. I think we cannot expect good results in working with depressed children unless the parents are involved in the treatment."[1]

On how doing hypnosis with children compares technically and relationally with hypnotizing adults: "First, I tell children and adults that I serve as their coach or teacher to facilitate self-hypnosis for them. I avoid the term *hypnotizing*, because it implies external control. In general, children remain close to their imagination and like to play. These characteristics make it easy for them to learn and enjoy self-hypnosis. They also lack abstract reasoning skills (most until at least age 16 years) and do not analyze themselves or the process to the extent adults do. I tell adults to 'pretend you are 8 years old' when you practice self-hypnosis."[1]

On how her knowledge of hypnosis influences her personal and professional values and volunteer efforts: "Basic principles in working with displaced persons and with developing country projects are to encourage persons in their personal coping skills, to develop ownership in programs, and to facilitate sustainability. When one thinks about these concepts, they are consistent with the goals in teaching self-hypnosis. Ninety percent of children are born into the developing world. What does or doesn't happen for them, especially in the crucial first 3 years, will impact everyone else in the world. We should all care, either from an idealistic perspective (which I prefer) or from a pragmatic perspective."[1]

[1] *Personal communications, November 27, 2002, updated May 10, 2011.*
[2] *Interview with Dan Short in the* Milton H. Erickson Foundation Newsletter*, Winter 1998.*

To set the presenting problem aside and engage with children, he'll ask questions such as, "What do you like to do that's fun? What do you like to do that you're not allowed to do?" Perhaps his most compelling question, though, is this one: "So, what do you do best?" (personal communication, June 10, 2010). At a time when children may be feeling frustrated, hampered by some symptom, Kohen's question introduces a shift in focus from the negative to the positive. It presupposes and thereby indirectly suggests that they are much more than their symptoms. It gives them a chance to talk to a doctor about something other than a problem, expanding their relationship. It gives them an opportunity to acknowledge a strength or resource and simultaneously gives Kohen the content basis for the therapeutic suggestions to follow.

Similarly, when simply asking questions about children's history in general and problem history in particular, the way questions are phrased and the way they answer are responded to can be powerful in establishing a therapeutic context. Berberich (2007) described some useful examples of this point in regards to conducting routine examinations of children. Whether using toys or drawings with younger children to help identify and express their concerns or using numerical rating scales with older kids to indicate their qualities of distress, the clinician can maintain an awareness to regularly communicate that symptoms are malleable, not fixed. How hypnosis is introduced (e.g., perhaps as an exercise in imagination), how children's role in the experience is defined ("you get to decide which channel you want to watch on your imaginary TV"), how children's questions or fears are answered, and how the parents (and their anxieties about their children's issues) are dealt with are just some of the variables that give definition to the therapeutic context. The merits of hypnosis, whether applied directly or indirectly, will be evident only to the extent that the therapeutic context fully supports its use. Pediatrician Karen Olness, MD, a pioneer in pediatric hypnosis, routinely emphasizes this important point.

HYPNOSIS IS DIFFERENT WITH CHILDREN

The experience of children is substantially different from that of adults. Those differences extend into the experience of hypnosis as well (Sugarman, 2007). At least some of the core components of hypnosis are paradoxical in nature; for example, I may be talking to you, a 5-year-old girl, about your doll and "how comfortable your doll looks sitting in that chair with you," but I am obviously not really talking about the doll at all. But at what age will a child understand or respond meaningfully to paradoxical suggestions? The doll being comfortable is a metaphor, and it contains an indirect suggestion for you to be comfortable. At what age and level of cognitive development will children respond to the identification and implication components of the story?

If children are distracted playing, whether with a game or toy as a young child or a computer game as an older child, is that quality of externally oriented distraction the equivalent of hypnosis when hypnosis generally involves striving to catalyze meaningful internal associations? If the distraction is externally oriented, will that enhance or diminish their capacity to form such associations? As clinicians, we typically want to know that children can generate a self-directed experience, whether imagery, fantasy, imagination, or following a line of thought to its conclusion.

Do children care about self-soothing or eye closure? Barabasz and Watkins (2005) don't think so: "The last thing most children would be interested in doing is closing their eyes, particularly if some sort of medical procedure is about to be performed" (p. 388). Rhue (2010) agreed: "As a rule, child hypnotherapy sidesteps the standard markers of a hypnotic induction, including direct suggestions for eye closure, relaxation, and sleepiness" (p. 471). Kohen and Olness (2011) sensibly suggested that *responsivity* is a more appropriate goal than hypnotizability in working with children. The implication is that you don't have to obtain eye closure and have children sit perfectly still while relaxing and listening attentively to your every word to be effective. The odds of children responding in this way simply are not that great. Doing formal hypnosis is less necessary than is being hypnotic, and from that position being direct or indirect will depend on clients' needs and responsiveness.

One of the most common reasons some practitioners come to question the responsiveness of children to hypnosis is the active nature of most children. Adults generally inhibit voluntary activity when in hypnosis, called *catalepsy*. In contrast, children often fidget and outwardly appear restless even though they may be very involved with the clinician and what he or she is doing (Kohen & Olness, 2011). If one has an inflexible expectation of how clients in hypnosis must look and behave, fidgety children will seem unaffected by hypnotic procedures. Sometimes, perhaps much of the time, a procedure with children can encourage and make use of their energy by engaging them in some activity such as a game that distracts them from what the clinician intends to communicate. Observation of children's interactions with their parents and siblings can provide a great deal of useful information about the kind of relationship—friend, ally, teacher, doctor—one may build with them to best help. Knowledge of their interests and emotional needs will also help one discover the best avenue of intervention. An exceptionally creative example of an engaging approach to children's problems is one of Milton Erickson's cases, described by Haley (1973) in *Uncommon Therapy* (1973). A young boy with the problem of enuresis was literally dragged in by his parents to see Dr. Erickson. Alone with the child in his office, Erickson angrily complained aloud about the audacity of the boy's parents. How *dare* they order him to cure the boy's enuresis! Erickson went on complaining about the parents for quite some time, and meanwhile the boy was entranced by this strange doctor's unexpected

rants against his parents, whom, not coincidentally, he was pretty angry with, too. When Erickson finally said he'd prefer not to deal with the boy's bedwetting at all, he shifted their "conversation" to talking about the muscle coordination necessary for the sport of archery, an interest of the boy's. By talking at length about growing up and the development of muscle control, Erickson was able to indirectly offer suggestions for the boy establishing control of his bladder muscles. Erickson's unusual intervention was a successful one, and it began by utilizing the boy's anger, first forming an alliance with him against his parents, or so it seemed, and then using the alliance to teach something the boy wanted to learn that was a perfect parallel to solving his problem. Such a case example illustrates points made earlier about using states of absorption to build new associations within clients, even associations not immediately in their awareness.

Induction Methods Utilizable With Children

Induction methods will necessarily vary according to a variety of factors, including the age, verbal level, personality, interests, responsiveness, and attentional style of child-clients. Bearing in mind that the induction is meant to focus and relax clients to build receptivity to the suggestions and experiences to follow, creatively utilizing what they have offered is generally a more reliable path than using structured techniques. As child therapist Joyce Mills (2001) wrote, "Play is the language of children, and *story* is the language of play" (p. 506).

Working With Younger Children

Use of Play With younger children, then, play can be an experiential means of connecting with a child and building responsiveness. Dr. Pamela Kaiser, a pediatric specialist and hypnosis expert who is codirector (along with Kohen) of the National Pediatric Hypnosis Training Institute, suggests that children under age 8 often prefer "bridging" toys, such as a shy turtle finger puppet hiding in its shell (Kaiser, 2011). The turtle has a story to tell while playing with the puppet, and the therapeutic message may get across through the telling. Holding a doll or stuffed animal or playing games of any kind that children find engaging can promote the absorption that leads to greater responsiveness to your suggestions.

Use of Imagination Barabasz and Watkins (2005) suggested the use of television imagery, in which children are asked what their favorite TV show is and are then asked to imagine watching that show. The show can be general or may include a suggestion to watch a character solve a similar problem. When the program is over they are urged to tell the therapist all about it. A similar technique is to ask children to role play in their imagination the part of a favorite character.

Magic Tricks The use of magic tricks to engage attention and build a connection is another technique. Making things "disappear" is a thinly disguised suggestion for symptom remission.

Stories Stories capture the imagination of children. Australian psychologist George W. Burns captured the power of stories in the introduction to his exceptional book *101 Healing Stories: Using Metaphors in Therapy* (2001), from which I quote:

> *Once upon a time* …. As my mother sat on the side of my bed at the end of each day and spoke these words, I was entranced. Four simple and oft-expressed words captured my attention and heightened a sense of anticipation about what may follow. Where would they lead? Would they take me on a journey into a fantasy or along a voyage of imagination? Would they guide me through lands I had yet to explore? Would they open my mind to experiences I had not yet discovered? Would they evoke emotions of fear, sadness, joy, or excitement? I snuggled into the bedclothes, closed my eyes, and enjoyed the anticipation of venturing on an unknown journey. Those times were special. There was something very intimate about the undisturbed temporal space of sharing a story. (p. xvii)

Burns captures the spirit of storytelling and highlights the expansiveness of storytelling as a means of engaging with another person. He followed this book with another, called *101 Healing Stories for Kids and Teens* (2005). Both provide insight into the art and skill of constructing and telling stories as a means of inducing and utilizing that attentive state we so greatly appreciate.

Pediatric nurse practitioner Linda Thomson has written two excellent books of therapeutic metaphors for younger children: *Harry the Hypno-potamus: Metaphorical Tales for the Treatment of Children* (2005) and *Harry the Hypno-potamus: More Metaphorical Tales for Children* (2009). Stories are wonderful at any age but obviously must be age appropriate and told in ways that appeal to the unique attributes of the individual (Mills & Crowley, 2001).

Some kids will get the lesson embedded in the story right away, some with a little encouragement to give the story some thought, and others will need some help grasping the message. Does it ruin the story to explain it? There is no evidence to support this concern. To the contrary, for it is a potentially powerful suggestion to affirm a helpful new possibility: "So, when you face that difficult situation, you can instantly remember this story I told and it will remind you that you can do something similar to feel better."

Working With Older Children

Older children and adolescents can usually be engaged in a more formal hypnotic process. The language of focusing, relaxing, and getting into a good frame of mind is usually readily accepted.

FOCAL POINT: CHILDHOOD DEPRESSION

As previously noted, being a kid these days is not easy. They face lots of challenges they are simply not intellectually and emotionally equipped to meet, challenges that are socially based that lead them to have higher rates of depression than any previous generation of kids. Epidemiological surveys over the last half-century show that the average age at which depression first strikes is steadily decreasing, and the number of young people suffering depression is steadily increasing. In my previous books, *Hand-Me-Down Blues: How to Stop Depression From Spreading in Families* (Yapko, 1999) and *Depression Is Contagious: How the Most Common Mood Disorder Is Spreading Around the World and How to Stop It* (Yapko, 2009), I detailed the family and cultural conditions giving rise to depression in children. I suggested we don't need a better *micro*scope to see the problem; rather, we need a better *macro*scope to see the social forces contributing to the rise in depression in all age groups, but especially kids. I also described the importance of "being the antidepressant family," that is, managing the family mindfully and skillfully, given the power of the family to either increase or decrease each member's vulnerability to depression.

The incidence of depression in the United States is currently greatest in the 25–44-year-old age group—adults who are in their prime child-bearing years. This means that the largest group of depression sufferers is raising the fastest-growing group of depression sufferers—their kids. Just having a depressed parent increases the chances of a child becoming depressed by a factor of at least three. It's why I have stressed observing not only children but also the social context of their problems. Depressed parents can't teach their children what they don't know. Thus, a young child's tummy aches, an older child's angry outbursts, an adolescent's sulking, and an older teen's drug use may all be variations in the appearance of depression that suggests the need for a closer look by parents and professionals. Depression in kids is too often overlooked simply because they don't say these words: "I'm depressed." (By the way, adults don't often say these words, either.)

Anxiety and avoidant coping in kids is a key early warning sign of emotional difficulties that can easily mushroom into eventually suffering anxiety and depression together. In fact, in the majority of adults, depression and anxiety coexist, but they don't usually have the same age of onset. Typically, anxiety precedes depression by many years; anxious children are much more likely to become anxious and depressed adults. Thus, the use of hypnosis as a vehicle for teaching relaxation, positive coping, and self-soothing to anxious children can serve as both treatment and an opportunity for prevention. The more complex uses of hypnosis to teach specific skills (e.g., problem solving, decision making) holds even greater potential for meaningful intervention with at-risk children. Kids need to be empowered with specific skills to counter the very real difficulties they face, whether it be cyberbullying, the suicide of a friend, or trying to get into a good school. Medicating kids with antidepressants is a relatively poor choice: even if there were good

antidepressants that were entirely safe and appropriate for kids, which currently there are not, drugs can't teach the salient skills.

It is appropriate to be concerned about today's kids and their rising levels of depression. The concern is even bigger than that, though: what happens when these kids grow up and have kids of their own? In the first study of its kind, epidemiologist Dr. Myrna Weissman from Columbia University and her colleagues (2005) followed three generations of high-risk families. The study took more than 20 years to complete. The findings are troubling, though not surprising: most of the grandchildren who had depressed parents and depressed grandparents developed anxiety disorders before they hit puberty that developed into depression as they became adolescents. In another study, Dr. Weissman followed the offspring of moderately to severely depressed parents from ages 15 to 35 and found that these children had a much higher probability of suffering anxiety disorders, depression, substance abuse, and social difficulties (such as shyness or fighting). As these children entered middle age, they had much higher rates of medical problems and even premature death. The risks to depressed children and the children of depressed parents are serious.

I included this special section in this chapter to shine a spotlight on the problem of childhood depression. Mental health professionals can too easily miss the diagnosis, sidetracked by other symptoms or problems. Given how powerful a force depression is in shaping children's developing brain, their emotional and social development, and magnitude of risk for all kinds of physical and emotional difficulties over the course of a lifetime, this problem can't be ignored. Learning how to recognize and treat children's depression is an especially urgent task for anyone who hopes to help them and their families.

Focus on Breathing The breath is a natural and easy focal point. Suggestions to "just notice the breath and to come back to it whenever the mind wanders" is a good focusing strategy, one shared by practitioners of mindfulness (Yapko, 2011b).

A Safe Place Creating an internal safe place, someplace inside to go to, can be a positive coping mechanism when used as a vehicle of detaching from stressful feelings or circumstances. Framing it as an "opportunity to create some space to handle things better later" rather than as a means of withdrawal is an important tool for emotional self-regulation (Kaiser, 2011).

Success Imagery Create or cocreate a sequence of behavior that children can follow that will lead to success in some important area of their life. Suggestions to relax, focus on this new approach, and "make it a part of you" can help establish the quality of positive expectancy that motivates clients to experiment with new ideas and helpful behaviors.

Accessing Good Feelings Suggest going to a favorite place (a concert, a party, a vacation spot) and recapturing the good feelings of that place and time. Kohen and Olness (2011) detail a wide variety of induction processes. All share the same optimism and permissiveness that transmits the messages to kids that *they* matter and they're capable of improving their lives by using more of their personal resources.

CHILDREN'S CONDITIONS TREATABLE WITH HYPNOSIS

A wide array of children's symptoms and issues can be meaningfully addressed with hypnosis. Only a few will be mentioned here, so the serious student of pediatric hypnosis will necessarily need to explore the clinical literature in greater depth. I recommend starting with Kohen and Olness (2011). The reference section at the end of this book provides an ample list of salient readings to peruse.

Kaiser (2011) wisely recommended an integrative pediatric approach as the appropriate standard for delivering treatment. She suggested such core components as "self-regulation skills training (e.g., self-hypnosis, biofeedback, breath retraining, autogenic training, progressive muscle relaxation), cognitive-behavioral therapy (CBT) and other psychotherapies (e.g., dyadic attachment work, parent counseling, family therapy), mind–body education, meditation, bibliotherapy, massage therapy, exercise consultation," as well as other approaches. She further pointed out that hypnosis is one component of a larger treatment plan, hopefully one combining a variety of approaches based on the needs of the child and his or her family.

Kaiser's point about hypnosis as but one component of a larger treatment plan is an important one to keep in mind. Kohen and Olness (2011) expressed the same perspective differently:

> Inasmuch as there is disagreement, confusion, and imperfect knowledge about hypnosis, these problems are greatly multiplied in the case of hypnotherapy. There are very few cases of "successful hypnotherapy," in which one can be absolutely certain that the results are due to hypnotherapy and not to something else. On the other hand, the usual clinical applications of medications do not take into account issues of placebo effect or suggestibility. With respect to hypnotherapy, some people are overly enthusiastic and make claims about hypnotherapy far in excess of the bounds of scientific responsibility. We take a middle position on this issue. We believe that when some patients are treated for some problems while in the state of hypnosis, changes occur that would not have occurred had the patients been in the usual state of awareness. (p. xix)

Similarly, I have made the point throughout this text that hypnosis cures nothing. Rather, it's what happens *during* hypnosis, the new associations established through the suggested shifts in perceptions, that have therapeutic potential. In describing various children's conditions treatable with hypnosis, it must be kept in mind that hypnosis was the vehicle for delivering meaningful ideas and suggestions to children, and these were the active ingredients of effective interventions. Thus, referring to the studies cited to learn what the detailed structure and content was of the applied hypnotic interventions will be necessary.

Habit Disorders Hypnosis has been applied effectively in the treatment of such habit problems as enuresis (Banerjee, Srivastav, & Palan, 1993; Collison, 1970; Kohen, Colwell, Heimel, & Olness, 1984; Kroger, 2008), encopresis (Linden, 2003), trichotillomania (Barabasz & Watkins, 2005; Barabasz, 1987; Zalsman, Hermesh, & Sever, 2001); coughing (Anbar, 2007), thumb sucking (Barabasz & Watkins, 2005; Kroger, 2008), and nail biting (Kroger, 2008; Marcus, 1963).

Behavioral Problems Hypnosis to address school refusal (Aviv, 2006; Lawlor, 1976), defiant behavior (Kroger, 2008), and other behavioral issues (Guyer, 2007) has been successfully applied.

Emotional Problems A broad array of treating emotional issues hypnotically in children have been addressed, including depression (Kohen, 2007; Kohen & Murray, 2006), anxiety (Kaiser, 2011; Wester, 2007), dreams and nightmares (Barrett, 2010b; Donatone, 2006; Kingsbury, 1993; Linden, Bhardwaj, & Anbar, 2006), needle phobia (Cyna, Tomkins, Maddock, & Barker, 2007), complicated bereavement (Iglesias & Iglesias, 2005/2006), and posttraumatic stress disorder (PTSD) and recovery from abuse (Linden, 2007; Rhue & Lynn, 1993).

Medical Issues and Pain Conditions The benefits of medical applications of hypnosis with children have been well documented and include the treatment of asthma and pulmonary conditions (Anbar & Hummell, 2005; Kroger, 2008), pain (Anbar, 2001; Kuttner, 1988, 2010; Kohen & Olness, 2011; Rogovik & Goldman, 2007; Wood & Bloy, 2008), tics and Tourette's syndrome (Kohen & Botts, 1987; Lazarus & Klein, 2010; Raz, Keller, Norman, & Senechal, 2007), headaches (Kohen, 2010; Kohen & Zajac, 2007), cancer pain (Kuttner, 1986, 1998; Kuttner, Bowman & Teasdale, 1988), palliative care (Kuttner, 2007; Liossi & White, 2001), procedural pain (Butler, Symons, Henderson, Shortliffe, & Spiegel, 2005; Kuttner, 1989; Liossi & Hatira, 2003; Scott, Lagges, & LaClave, 2008), irritable bowel syndrome (Vlieger, Menko-Frankenhuis, Wolfkamp,

Tromp, & Benninga, 2007), and differential diagnosis of epileptic and nonepileptic events (Olson, Howard, & Shaw, 2008).

CLOSURE

Conditions of childhood and how well or poorly they are managed can set up a lifetime of greater or lesser wellness and satisfaction. In this chapter, I have emphasized the importance of encouraging greater self-mastery in children through hypnosis in whatever treatments one provides. When children learn to distinguish what is controllable from what is not, they can then learn more easily what might be changed (i.e., *primary control*) and what requires adapting to in healthy ways (i.e., *secondary control*). Hypnosis is an exceptionally valuable means of encouraging both primary and secondary control; through hypnosis, children can learn that even if they can't control what's going on they can certainly learn to manage their response to whatever's happening. This is the core of self-mastery, and it's one of the greatest gifts a clinician can share with a young person.

FOR DISCUSSION

1. Do you think today's kids have it tougher than in previous generations? Why or why not?
2. If you could protect your child from all harm, even small ones, would you do so? Why or why not?
3. Do you think children should have a "quiet time" at school, as in the "good old days" when kids would lay quietly for 20 minutes each afternoon? Why or why not?

THINGS TO DO

1. Interview hypnosis experts and ask them whether they think children are easier or harder to hypnotize. What do you find out?
2. Research child development. Then take the same suggestion and it adapt it to be age-appropriate for kids ages 5–18.

CHAPTER 25

CLINICAL HYPNOSIS IN THE MANAGEMENT OF PAIN

The heartbreaking suffering of people we love, respect, admire, and perhaps would even self-sacrificingly trade places with if only they could get some relief motivates an earnest desire to help reduce that suffering. The spouse whose body aches in ways that defy medical diagnosis, the young son or daughter who needs to undergo a lengthy and painful diagnostic procedure, the parent who suffers a chronic, debilitating disease, the close friend who was seriously injured in an accident, the coworker who is fighting the ravages of cancer, the brave soldier from down the block who returns from war with limbs missing and battlefield injuries so horrific that even their doctors involuntarily wince when seeing them represent only a small fraction of the (too) many ways that people can suffer pain that tears their lives apart. It is difficult to imagine there being any more compassionate and rewarding experience of applying clinical hypnosis than in the relief of pain and suffering.

In this chapter, we will explore the use of clinical hypnosis in helping people manage pain. As you will learn, a great deal of scientific evidence has been amassed supporting the use of hypnosis in pain management. Only a very small fraction of that evidence will be presented here, so the interested practitioner will necessarily need to do a great deal of additional study of this topic to be truly knowledgeable and effective. I know of no more complicated, sophisticated, and urgent use of clinical hypnosis than in the realm of pain management.

THE COMPLEXITY OF PAIN

We need a neurological capacity for pain if we are to survive. How else can we avoid injury or respond to injury as quickly as possible before it worsens? Consider this colorful description:

> Pain is the human bodyguard, the cop on the beat racing to the scene, sirens wailing, shutting down traffic. You've been cut, burned, broken: pay attention, stop the bleeding, apply heat, apply cold, do something.… But what happens when pain goes rogue, when it sends off false alarms so that all the sirens keep sounding, all the cops keep coming, all the hurts keep hurting.… Rather than saving lives, it wrecks them … it becomes an illness in itself. The result: persistent, unceasing torment. (Park, 2011, p. 64)

Pain has what is commonly termed a *signal value*. It screams at us that something is wrong and needs immediate attention. This is termed *acute* pain. It is generally of short duration and leads one to take some immediate steps meant to resolve it. But pain is not a one-dimensional phenomenon, affecting only the body in specific ways that are obvious in indicating what will help relieve it. Sometimes the pain directly misdirects us to focus on a site that broadcasts the pain but does so from a transmission signal that actually originates somewhere else, a phenomenon called *referred* pain. Once pain has been recognized and responded to—the diagnostic tests have been run, perhaps the source has been identified (even though quite often it never is), and the pain persists even with appropriate treatment—the pain has now lost its signal value. The pain is termed *chronic*, some would suggest after crossing a 6-month timeline (Keefe, 1982), and is an ongoing pain that serves no useful purpose anymore, causing myriad problems that spider out into all areas of the life of the patient. There is recent neuroscientific evidence that chronic pain can be imprinted in the brain, amplifying its enduring qualities and complicating its resolution (Jensen, 2011a, 2011b; Patterson, 2010). Pain can thus take on a life of its own, turning a previously healthy person into a doctor-shopping, pill-popping, constantly complaining desperate individual that can focus on little else but the pain, the pain.

The infiltration of the pain into all parts of individuals' lives seriously complicates the treatment process. The physiology—specifically the neurology of pain—is certainly the focus of the treating physician. But as we have seen many times throughout this volume, focusing on physiology alone is too narrow a lens for providing adequate treatment. How does pain affect individuals' mood and vice versa? How does pain affect persons' motivation to pursue and follow treatment recommendations or even just to go back to work eventually? How does pain affect the quality of people's thoughts (cognitions), emotions, and behavior? What impact does pain have on people's relationships? What about the effect on their spirit and spiritual beliefs? How might it stress them

financially or legally when a lengthy lawsuit may be involved? Any and all of these different dimensions can combine to make recovery a challenging endeavor and the management of pain a complicated but vitally important goal.

Pain clinics and treatment centers have generally been most responsive to the recognition of pain as a multidimensional phenomenon. A team approach is relatively common, with physicians, psychologists, physical therapists, occupational therapists, nurses, and other professional team members each contributing to the comprehensive care a chronic pain patient receives. Any and all of these team members may—and should—have some in-depth knowledge of the merits of hypnosis as part of the treatment plan. The point is clear: underestimating the complexity of pain can too easily lead to undertreatment, either making matters worse or simply not making it possible for them to get better. Clinical hypnosis can help, but it has to be part of a larger treatment plan.

HYPNOSIS AND PAIN: WHAT THE HISTORY OF HYPNOSIS ESTABLISHED

The medical use of hypnosis for managing pain has been well described for over 2 centuries. One particularly compelling narrative of the use of *mesmerism* is found in the work of James Esdaile (1805–1859), a Scottish surgeon serving in India in the mid-19th century before the introduction of chemical anesthesia. Esdaile documented 345 major surgeries, including amputations, with hypnosis as the sole anesthetic. These he described in his fascinating book *Mesmerism in India, and Its Practical Applications in Surgery and Medicine* (1846/2010; see also Kroger & Esdaile, 1957). Not only did Esdaile successfully perform surgeries that were extraordinary, such as the removal of 70-pound scrotal tumors with hypnosis alone, but also his patients had only a fraction of the complications (e.g., postsurgical infections, bleeding, mortality) that others performing similar surgeries had at that time.

In the early part of the 20th century, largely riding the wave of psychoanalytic influence in which physical symptoms, including pain, were viewed as psychogenic, or psychologically generated, presumably for serving some unconscious need, hypnosis was used by some as a foundational practice of psychosomatic medicine. William Kroger (1906–1995) was a pioneer in this area and wrote a highly influential book (with Dr. S. Charles Freed) called *Psychosomatic Gynecology: Including Problems of Obstetrical Care* (Kroger & Freed, 1951), which introduced many physicians to the potential value of hypnosis in treatment. Compelling well beyond that text, though, was Kroger's filming of a childbirth carried out during hypnosis. This stark film provides a dramatic, highly successful demonstration of hypnosis in the management of pain associated with labor and delivery, including surgical repair following the birth. It is a graphic but highly impressive film. Two years later, Kroger

filmed a thyroidectomy performed on a young woman employing hypnosis as the sole anesthetic. It, too, is a graphic and highly educational film. Both of these historic and amazing films from the mid-1950s are now available; they are contained on a DVD sold with the revised second edition of Kroger's classic hypnosis text *Clinical and Experimental Hypnosis* (2008).

Early uses of hypnosis in medicine and surgery are impressive, to be sure. There is a substantial literature describing these (Crabtree, 1993; Gravitz, 1988; Hammond, 2008; Rosen, 1959; Rosenfeld, 2008), and it makes for fascinating reading. These early pioneers of mind–body medicine paved the way for modern studies and applications of hypnosis in the relief of pain. Let's jump ahead to the current state of affairs.

HYPNOSIS AND PAIN MANAGEMENT: EVIDENCE AND CURRENT APPLICATIONS

What empirical evidence is there that hypnosis can be effective in the management of pain? It often surprises people to discover that pain management with hypnosis is probably the most empirically well-supported application of hypnosis there is. Why has hypnosis been studied so extensively for its ability to reduce or even eliminate pain? There are several likely reasons:

1. Hypnotic analgesia and anesthesia represent the most dramatic applications of hypnosis. Seeing someone manage a painful condition comfortably or watching someone go through something as intense as a surgery with no anesthetic is impressive by any standard.
2. The benefits of hypnosis for pain relief can be more easily objectively measured than other applications of hypnosis, such as age regression. When someone learns hypnosis and then reduces or eliminates the use of pain medications, for example, you have a clear measure of a beneficial effect. Likewise, with newer scanning technologies in which brain changes may be evident when comparing before hypnosis and during hypnosis conditions (described in Chapter 4), combined with subjective reports of pain perception, the effect can also be more readily evident.
3. The prevalence of pain and the profound impact it has on people's lives, as well as the pressures pain conditions place on health-care systems and individual providers, makes pain a high value target. So pain gets a great deal of attention, as well it should.

There have been many studies examining the merits of hypnosis for pain management. Psychologist David Patterson is a professor in the Departments of Rehabilitation Medicine, Surgery, and Psychology at the University of Washington School of Medicine. Dr. Patterson published a critical review of the

research in 2004, concluding unequivocally that the literature indicates hypnosis can be effective for both acute and chronic pain. He provided a comprehensive review of the literature on hypnosis for pain management, as well as techniques to employ, in his text *Clinical Hypnosis for Pain Control* (Patterson, 2010). Dr. Patterson, and a colleague also from the University of Washington, psychologist Mark Jensen, a professor and vice chair for research in the Department of Rehabilitation Medicine, published a narrative review of the research evidence in 2003 in the *Psychological Bulletin*. Jensen wrote a book called *Hypnosis for Chronic Pain Management* (2011a), which explains well the biology of pain and then spells out in detail ways to apply hypnosis in treatment. Additionally, Jensen's book comes with a practical workbook for the patient (2011b).

A recent meta-analysis (Elkins, Jensen, & Patterson, 2007) featured a review of controlled prospective trials of hypnosis for treating chronic pain. Results showed that "hypnosis interventions consistently produce significant decreases in pain associated with a variety of chronic-pain problems. Also, hypnosis was generally found to be more effective than nonhypnotic interventions such as attention, physical therapy, and education" (p. 275). In another recent meta-analysis evaluating the merits of hypnotically induced analgesia conducted by Montgomery, DuHamel, and Redd (2000), hypnosis provided significant pain relief for about 75% of the population. Further analysis indicated that hypnosis appears to be at least as effective as other nonphysical approaches, such as cognitive-behavioral pain management approaches. And there is evidence that when hypnosis is added to standard patient-controlled sedation, hypnosis affords significantly greater pain relief than does conscious sedation alone (Lang et al., 2000). The benefits of hypnosis are substantial: hypnosis is not addictive, it is empowering to the patient, and it encourages a healthy proactive role in managing pain (Jensen, 2011a; Lynn & Kirsch, 2006; Patterson, 2010).

Hypnosis has been used successfully in the treatment of all kinds of painful conditions, including headaches in adults (Barber, 1996a; Hammond, 2007; Spinhoven, Linssen, Van Dyck, & Zitman, 1992) and children (Anbar & Zoughbi, 2008; Kohen & Zajac, 2007), fibromyalgia (Martinez-Valero, Castel, Capafons, Sala, Espejo, & Cardeña, 2008; Catell, Perez, Sala, Padrol & Rull, 2007), burns (Askay, Patterson, Jensen, & Sharar, 2007; Ewin, 1983; Patterson, Hoffman, Weichman, Jensen, & Sharar, 2004), cancer and terminal cancer (Elkins, Cheung, Marcus, Palamara, & Rajab, 2004; Levitan, 1992; Liossi, 2006; Lynch, 1999; Nèron & Stephenson, 2007; Rajasekaran, Edmonds, & Higginson, 2005), chemotherapy-related distress (Dupuis & Nathan, 2003; Marchioro et al., 2000; Richardson, Smith, McCall, Richardson, Pilkington, & Kirsch, 2007), invasive and noninvasive medical procedures in adults and children (Butler, Symons, Henderson, Shortliffe, & Spiegel, 2005; Flory, Salazar, & Lang, 2007; Richardson, Smith, McCall, & Pilkington, 2006; Wild & Espie, 2004), dental conditions and procedures (Hassett, 1994; Mackey, 2010; Mulligan, 1996),

surgical procedures (Bejenke, 1996; Montgomery, David, Winkel, Silverstein, & Bovbjerg, 2002), irritable bowel syndrome (Galovski & Blanchard, 1998; Gonsalkorale, Houghton, & Whorwell, 2002), labor and delivery (Brown & Hammond, 2007; Kroger, 2008), back pain (Nusbaum et al., 2011; Tan, Fukui, Jensen, Thornby, & Waldman, 2010), and many, many other conditions too numerous to include in this general overview.

GETTING STARTED: INTERVIEWING INDIVIDUALS IN PAIN

Having already emphasized (1) the importance of being medically supervised if you are not a physician, documenting in your case notes your discussions with clients' primary physician regarding your treatment plan; (2) the need to have accurate and current information about clients' condition (including the full nature of the illness or injury, salient symptoms, general course, and prognosis); (3) a sensible, albeit general, treatment plan; and (4) a good working relationship with clients in which hypnosis has been discussed and agreed to as an approach, then the first step in the direction of getting the hypnosis under way is to interview them more specifically about their subjective experience of pain. There is a great deal of information that would be helpful to have, of course, but in this section I will describe just some of the vitally needed information.

The Pain Narrative

Pain is a subjective phenomenon, privately suffered. Thus, if a clinician wants to help, he or she will have to ask clients useful questions about the experience of pain. The way people explain their pain, especially the specific language they use in describing its qualities, is invaluable information in helping structure an intervention with hypnosis. The narrative is an affirmation of the pain, an acknowledgment of its presence and numerous effects. Like any narrative, whether for pain, depression, anxiety, or what a person's high school graduation was like, the narrative itself becomes part of the experience. It's a story told over and over again, increasingly making more rigid the way individuals represent the experience not only to others but also especially to themselves.

What are the characteristics of persons' narrative? Many different characteristics could be focused on, each influencing not only their way of experiencing the pain but also how the clinician must then form a tailored response. These include such characteristics as (1) whether clients anticipate the pain will be a never-ending burden or a temporary challenge; (2) whether the pain has some meaning that makes it explainable (whether a biological explanation, such as

nerve damage, a spiritual explanation, such as a punishment from God, or some other explanation); and (3) whether clients sense any ability to alter their experience of the pain.

Additionally, it is important to know the following:

1. What prior treatments individuals have received, especially if hypnosis was involved, and whether these were of any help. You don't want to duplicate previously failed approaches.
2. The impact of the pain on other areas of clients' lives, including self-esteem, mood, relationships, ability to work, and capacity for enjoyment.
3. What clients' level of functioning was before the illness or injury, called the *premorbid functioning*.
4. Whether there are any additional external complications, such as an impending lawsuit related to the painful condition. If the person is going to court on a case involving the pain's onset, such as a car or industrial accident, and the court date isn't for another 10 months, then getting out of pain now will diminish any possible financial award the person may be given—a fact of which the person is well aware. This is one of the very few scenarios where a so-called secondary gain issue (i.e., a reinforcement for maintaining one's symptoms) can legitimately be found, and it can doom an intervention before it begins if not handled skillfully.

Obtaining a detailed sensory description of the pain is an especially valuable source of information for the clinician. Typically, pain will be described with adjectives that reflect a *thermal* quality (e.g., hot, burning, cold, frozen), a *kinesthetic* quality (e.g., dull, aching, sharp, stabbing), and a *temporal* quality (e.g., continuous, constant, intermittent, unpredictable). People may occasionally use other adjectives as well that reflect *visual* qualities (e.g., a dark cloud, a piercing arrow) and auditory qualities (e.g., it screams at me, it howls through me). The adjectives individuals spontaneously employ in describing their pain are most often the clues to the clinician as to what might be suggested in hypnosis. If clients describe the pain as hot, for example, then suggestions for cooling make sense. If the pain is described as sharp, then suggestions for "a dulling erosion" may be effective. If the pain is continuous, then asking about any fluctuations they may notice in the pain might yield useful information to amplify, and offering suggestions for "unexpectedly noticing periods of comfort interrupting the discomfort" may be of help.

Another vital bit of information to obtain from clients concerns the rating of the level of pain as well as the level of suffering they experience. Clients are asked to rate on a scale of 0–10 the level of pain, zero being no pain and 10 being the most excruciating pain imaginable. They are then asked to similarly rate from 0 to 10 the level of suffering, zero being no suffering and 10 being suffering horribly. Comparing these ratings gives one a sense of their pain threshold, that is, how well they manage pain. For example, a pain level of 7

but a suffering level of only 4 suggests a high pain threshold. Conversely, a pain level of 4 and a level of suffering of 7 suggests a low threshold. One way of thinking about the benefits of hypnosis for pain management is as a means of raising peoples' pain thresholds.

The Emotional Side of Pain

Jeffrey Feldman is assistant professor of neuropsychology at Wake Forest University Baptist Medical Center in Winston-Salem, North Carolina. Feldman has paid particular attention to the emotional dimension of pain and with good reason: "A negative emotional state increases pain sensitivity and reactivity, especially negative pain affect" (Feldman, 2009, p. 251). In an earlier paper, Feldman (2004) detailed the neurobiology of pain, affect, and hypnosis. Reporting on the data describing differential effects on pain and the emotion associated with pain derived from neuroimaging studies, Feldman stated, "The affective dimension of pain … is most associated with autonomic arousal and subjective distress.… Experimental neuroimaging studies indicate that hypnosis can reduce pain affect or pain sensation based upon the wording of the suggestions.… Hypnosis can similarly and potentially more effectively activate positive state dependent learning" (Feldman, 2009, p. 251). Using the interview as a vehicle for assessing the quality of clients' emotional state relative to pain, Feldman (2009) recommends offering suggestions that address both the pain and related affect for a fuller effect.

Clients' emotional state is important to consider, as was discussed in Chapter 5. When clients first encounter pain in its acute phase, the most common emotion is some combination of anxiety and fear. They naturally begin to think catastrophically: What if they can't fix this? What if I am in pain forever? What if I can't work and support myself or my family? These are truly scary questions, so it is no surprise why anxiety is a key factor in acute pain. When the pain transitions from acute to chronic, the most common emotion is some combination of depression and sadness. Clients ask impossible questions: Why them? Why is this happening? Won't they ever get their life back to how it used to be? How can they possibly adjust to this? These are sad and depressing questions, amplified by the fact that no amount of asking them over and over will bring one any closer to good answers.

In a large-scale study by the World Health Organization (WHO), reported by University of Texas at Arlington psychologist Robert Gatchel (2004) in his American Psychological Association award address, 5,438 patients from 15 primary care sites and 14 countries were studied: "Of the 22% of patients who reported persistent pain for more than six months, there was a fourfold increase in associated anxiety or depressive disorders. These relationships were consistent across cultures" (Gatchel, 2004, p. 795). Feldman (2009) and Gatchel confirmed what any pain specialist is likely to say: there's much more

to pain than only unpleasant sensations. Individuals' emotions require special consideration, and hypnotic suggestions for pain relief need to be targeted to address them.

Jensen (2011a) provided detailed and structured forms for interviewing the individual in pain. Patterson (2010) also provided an interview guide, especially emphasizing the technique of motivational interviewing (MI), an effective style of interviewing that builds a momentum toward therapeutic change by the way questions are worded and sequenced. Feldman (2009) provided additional fresh insights into how suggestions may be worded when striving to address clients' emotions as well as the experience of pain.

GETTING UNDER WAY: UTILIZING HYPNOSIS WITH INDIVIDUALS IN PAIN

The general goal in applying hypnosis for pain relief is obvious: absorb individuals in pain in a frame of mind and body that is sufficiently incompatible with the experience of pain to alter and reduce it. Many different approaches to pain relief are commonly described in the pain literature. Virtually all make direct or indirect use of dissociation as an initial step in the direction of facilitating hypnotic analgesia or anesthesia. Even an effective approach such as mindfulness for pain relief (Dahl, Wilson, Luciano, & Hayes, 2005; McCracken & Eccleston, 2005) utilizes dissociation as the foundation: the suggestions are offered both implicitly and explicitly to "detach from the pain" and "detach from your judgments and thoughts about the pain." So, in building the momentum of the session in the direction of encouraging more than acceptance—facilitating an actual sensory shift in clients' subjective experience—the session must progressively intensify the dissociation and ideo-plastic faculty (discussed in Chapter 5) that may make it possible for those sensory shifts to occur. Rather than just launching into a pain relief strategy following an induction, taking the time (assuming time permits, which isn't always the case) to build the response set carefully and encouraging a greater degree of dissociation that allows clients a comfortable distance from their usual awareness is important in helping to generate benefit.

The same generic structure for a hypnosis session described earlier applies when working with individuals in pain as when working with any other kind of problem: after all, every hypnosis session has a beginning, middle, and end. First comes orienting clients to hypnosis ("you can arrange yourself in a comfortable position"), then securing their attention and beginning the induction ("as you begin to focus on my words, you can notice your eyes closing … and as your eyes close, you can notice your thoughts going in many different directions … just before they begin to slow down … making it even easier for you to get absorbed"), and then building a response set to introduce the

general idea that the experience of their body is variable ("isn't it interesting how different our experience of our body can be from moment to moment … sometimes we feel more energetic … sometimes more tired … sometimes we feel warm … sometimes a little cold"). At this point, with the hypnosis session now well under way and the goal of facilitating pain relief clearly established, the clinician can launch a strategy that will, hopefully, engage them and activate their potential to respond meaningfully.

HYPNOTIC STRATEGIES FOR ENCOURAGING RELIEF FROM PAIN

This section lists and describes 12 distinct strategies for facilitating hypnotic analgesia and anesthesia for pain relief (Table 25.1). A small sample of the wording that represents the core of each approach is also provided.

Direct Suggestions for Numbness and Pain Relief

As Barabasz and Watkins (2005) stated, "The first and simplest approach is for therapists to inform hypnotized individuals that they will no longer feel the pain" (p. 232). Can such simple, straightforward suggestions really work? Perhaps surprisingly, the answer is yes. In fact, if you are able to watch the historic films mentioned earlier in this chapter made by William Kroger, impressively demonstrating hypnosis during a childbirth and a thyroidectomy, you will no doubt observe that Kroger's approach is both direct and authoritarian.

Table 25.1
Approaches to Pain Management With Hypnosis

1. Direct suggestion
2. Indirect suggestion (e.g., interspersal, metaphor)
3. Amnesia
4. Sensory alteration (e.g., analgesia, anesthesia, shifting primary representational system)
5. Symptom substitution
6. Symptom displacement
7. Dissociation (e.g., generalized, localized)
8. Confusion (e.g., sensory overload, pattern interruption)
9. Gradual diminution
10. Regression to prepain period
11. Pseudo-orientation in time
12. Time distortion

He literally tells his patient, "Your arm is becoming anesthetic," and somehow his patient is able to translate that suggestion into an effective response. A direct suggestion for "that part of your body becoming number and number" can be enough for some hypnotically talented individuals to experience comfort. Patterson's (2010) suggestion that "you will feel nothing but comfort and complete relaxation" is also a good suggestion because it can prevent the fear in some clients that "feeling nothing at all" is associated with death (p. 122).

Direct suggestion of analgesia as an approach involves offering suggestions for the lack of sensation in the specific part of clients that is painful. If, for example, a client is experiencing pain in his abdomen, a direct analgesia approach might be structured as follows:

> … And as you feel your arms and legs getting heavier … you can see the muscles in your abdomen loosening … relaxing … as if they were guitar strings you were slowly unwinding … and as you see those muscles in your abdomen relax … you can feel a pleasant tingle … the tingle of comfort … and whenever you have had a part of you become numb, like an arm or leg that fell asleep … you could feel that same tingle … like the pleasing tingle in your abdomen now … tingling more … and isn't it both interesting and soothing to discover the sensation of no sensation there? That's right … the sensation of no sensation … a tingling, pleasing comfortable feeling of numbness there.

When you suggest the "sensation of no sensation" directly in the client's abdomen, he can experience diminished sensation and direct relief in the troublesome area. However, there is also likely to be greater resistance attached to the troubled area given its emotional toll on him. Therefore, going after the analgesia response directly in the afflicted area may, with some individuals, be less likely to be effective. Much of this will be determined by the quality of clients' expectations about the likely success of hypnotic suggestions for pain relief (Green & Lynn, 2011; Kirsch & Lynn, 1995). Directly suggesting numbness or the feeling of just having received an injection of Novocain will likely be effective with more responsive clients (Barber, 1996b; Crawford et al., 1998; Eimer, 2000).

The Glove Anesthesia Technique

A slightly less direct approach is called *glove anesthesia*. In this sensory alteration process, patients are given suggestions to experience full numbness (i.e., anesthesia) in either or both of their hands. Most people seem to be able to do this, if not fully, at least in part. When the glove anesthesia has been accomplished, further suggestions may be given that the anesthesia can be effectively transferred to whatever part of the body that patients choose. Glove anesthesia permits mobility for the anesthesia when the clinician suggests that a touch of the anesthetized hand to any part of the body will directly transfer

the sensation of numbness to that spot. (In contrast, a direct suggestion for analgesia does not have such mobility, since it is localized to a specific, fixed spot.) This is particularly helpful when the location of individuals' pain varies: today it is here, but yesterday it was someplace else. Suggestions for glove anesthesia might take the following form:

> … And in a moment, when I take your hand with your permission, I'm going to place it in a position in which it can stay easily and comfortably (clinician takes the client's hand and props it up on the elbow) … and you can easily hold your hand in this elevated position … and as you do so you can notice how … this hand begins to feel different from your other one … more distant and even removed from you … more distant … and while the rest of you remains warm and comfortable … this more distant hand can begin to experience a sensation of coolness … almost as if a cold wind were floating over your hand … cooling it, chilling it … and as your hand gets comfortably colder … and still colder … while the rest of you remains comfortably warm … the pleasantly cool feelings in your hand get stronger … cooler … colder … and as your hand continues to get comfortably colder … it can tingle pleasantly with a cool numbness … and when I touch your hand … you can realize that the only sensation you feel is a cool numbness … and you can place your hand anywhere else on your body you'd like to feel that same cool pleasant numbness.…

In this example of glove anesthesia, the sensation of numbness is built around a suggested change in perception of temperature, that is, the coolness of the hand. Descriptively suggesting in sensory detail the experience of making snowballs bare-handed or the experience of reaching into the freezer for a tray of ice cubes can help facilitate the experience of coolness and numbness.

Indirect Suggestions for Pain Relief: Metaphor and Interspersal of Suggestions

Indirect suggestions for pain relief are generally accomplished through the use of metaphor and the interspersal or "sprinkling" of suggestions for comfort throughout the process. In *The Case of Vicki*, the demonstration accompanying this book involving my session with a terminal cancer patient, you may notice that I utilize many indirect suggestions interspersed with comforting words, both in the interview and the hypnosis session itself.

A well-known example of indirection comes from the work of Milton H. Erickson, who described in detail an intervention with a man named Joe suffering the painful ravages of terminal cancer (Erickson, 1966/1980). Joe had been a florist most of his life, a fact that Erickson utilized heavily in his use of metaphor. Joe was most adverse to the idea of hypnosis, based on common

misconceptions, but was willing to see Erickson for pain relief. Erickson's approach was, therefore, indirect, as you will see from the following abbreviated excerpt:

> I know you are a florist, that you grow flowers.… I'm going to say a lot of things to you, but it won't be about flowers because you know more than I do about flowers.… Now as I talk, and I can do so comfortably, I wish that you will listen to me comfortably as I talk about a tomato plant.… One puts a tomato seed in the ground. One can feel hope that it will grow into a tomato plant that will bring satisfaction by the fruit it has.… It's so comfortable, Joe, to watch a plant grow.… (pp. 269–270)

Erickson explained the success of the technique utilized with Joe in this way:

> Joe had no real interest in pointless, endless remarks about a tomato plant. Joe wanted freedom from pain, he wanted comfort, rest, sleep. This was what was uppermost in Joe's mind, foremost in his emotional desires, and he would have a compelling need to try to find something of value to him in the author's babbling. That desired value was there, so spoken that Joe could literally receive it without realizing it. (pp. 271–272)

As we have seen, the value of indirection is evident when more direct approaches are not viable for whatever reason. The content of the metaphor matters for engaging clients' interest, of course, but the structure of the delivery, especially making use of embedded suggestions for comfort sprinkled liberally throughout the process, is what likely makes the experience potentially beneficial.

The Mind–Body and Physical Dissociation Approaches

Dissociation involves the capacity to divide global experiences into their components, including individuals' attentional, sensory, and behavioral abilities. Suggestions for physical dissociation can lead them to have the subjective experience of feeling separated from all or part of their body, including the pain. Can you recall a time when you may have felt, however briefly, as if your body was going through something you didn't feel as though you were apart? After receiving chemical anesthesia, for example, you can watch yourself get stitches; you know the doctor is sewing your skin together, but since there is no feeling present the experience can just appear to be a curious procedure you watch but from which you feel removed. Even though intellectually you knew you were "all together" at the time, you may have felt distant and removed from the physical experience. That kind of detached experience is representative of dissociation.

Physical dissociation as an approach to eliciting analgesia can involve guiding clients into the subjective experience that their mind and body exist on

two different levels. Suggestions are given that there can be sufficient distance between them for clients not to notice (or feel) what their body is experiencing. The following sample illustrates this approach:

> … And when your thoughts begin to travel faster than your body can keep up with … you can rediscover how your mind can travel so far and so fast … and you can wonder about things that exist in the universe … the size of the mighty ocean … the age of huge trees that seem to fill the sky … and the number of stars in the sky … things you have probably wondered about from time to time … and you can let your mind float freely to the place you find yourself drawn to … while your body stays here … comfortably here … no need to move it … no need to let it hold your mind back … you can just enjoy the freedom of letting your mind float freely … to the places you most enjoy … and while your mind is there … and your body is here … it can be so comforting to know that your body is here … waiting … comfortably … patiently for as long as you'd like to float freely … without having to notice it … because your mind can comfortably go anywhere it wants to go.…

Suggesting that the mind "go somewhere" encourages a physical dissociation when the body isn't invited to go along. Such separation can even be maintained beyond the formal hypnosis session when posthypnotic suggestions are offered that tie the capacity for physical dissociation to events in everyday living. It's important to remember that offering posthypnotic suggestions for comfort even after the hypnosis session is a vital consideration in planning pain management strategies for your clients.

Suggesting the dissociation of mind from body is one use of dissociation, while dissociating one part of the body from the rest of the body is another. "Your arm can drift away from the rest of your body while your body relaxes deeply," or, "Your left side can drift off while you enjoy the right to be comfortable," are examples of such physically dissociative suggestions.

The Hypnotic Displacement of Pain

The displacement of the pain might mean "moving the pain" (i.e., shifting the perception of the location of pain from one area to another more easily tolerated one), or it might mean restricting the perception of the pain to a smaller and less inconvenient area. For example, a client experiencing pain in her arm might be given the following suggestions for displacement:

> … As you start to recall how you learned long ago about your body … as all people eventually must … you might begin to remember learning how delicately but wonderfully balanced the body is … a muscle that allows you to bend your leg has a counterpart that allows you to straighten your leg again … and while there are muscles that let your

> head lift … there are also muscles that … let your head drop down … deeply relaxed … and there is a part of you that can feel comfort where there was once discomfort … and as the comfort flows into the area where you'd most like it … and dislodges the discomfort, letting it flow down … and as you feel it flowing down your arm … you can feel it collecting in your baby finger … so small there … and so easy to forget about.…

Transferring the pain of an arm to a baby finger can allow for a higher level of functioning and less preoccupation with discomfort since it can become confined to such a small and more easily managed part of the body. Essentially, this is a strategy of "symptom substitution," the deliberate creation of a new "outlet," one that is now within better control.

Confusion Techniques for Pain Relief

Milton Erickson originated and developed creative techniques for deliberately inducing confusion in clients as a means of reducing their rigidity while absorbing and redirecting their attention (Erickson, 1964a; Gilligan, 1982, 1987). In an earlier paper (Yapko, 1988a), I described different types of confusion and their particular relevance in treating individuals in pain. Each form of confusion involves an interruption of a usual pattern, desirable as a precursor to developing a new, more adaptive pattern in coping with pain issues.

Confusion techniques can be aimed at any rigidly adhered to patterns on any or all of these dimensions: cognitive, sensory, relational, temporal, and affective.

- On the cognitive dimension, the clinician may attempt to disrupt negative expectations, negative interpretations about the meaning or purpose of the pain, negative beliefs about the ability to manage the pain, and other such self-limiting cognitive appraisals.
- On the sensory dimension, confusional suggestions may be employed to disorient clients in terms of how sensory-based experience is perceived.
- On the relational dimension, the clinician might strive to disrupt clients' self-limiting expectations of others or any interpersonal patterns (e.g., guilt mongering) that exacerbate the pain.
- On the temporal dimension, confusing suggestions may be given regarding the passage of time and for time-related variables such as memory of past events or future expectations.
- On the affective dimension, suggestions to disrupt negative emotional associations to pain may be offered as more positive and motivating possibilities are embedded within the confusion.

The following is an example of confusional suggestions on the temporal dimension that encourage a shift in perceptions for the amount of time one can be comfortable:

> … And you really don't know whether you will be comfortable in 1 hour or in 2 days … or whether it will be 2 days of comfort in 1 hour or whether you'll be more comfortable in the 1 hour after the next hour of comfort that precedes the hour of relief that comes for 2 full days now … and then you may start to realize that your growing comfort today will still be there tomorrow … and tomorrow when tomorrow becomes today and you transfer the comfort from yesterday to today to tomorrow every today and tomorrow you can breathe a deep sigh of relief knowing your comfort is still growing.…

Guiding clients' emotional associations through a variety of inputs that intend to amplify different emotions simultaneously can disorient them from the negative feelings about their painful condition. By absorbing them in a search for some adaptive reorganization of emotions, the clinician can access and amplify positive feelings that can also serve the purpose of enhancing client motivation. The following is an example of an affect-based confusion approach:

> … Maybe you can remember what it's like to be a child … to really capture a good feeling … for how that little boy I told you about earlier in our session who was so curious must have felt … he was so curious about what it would be like to be a grown-up … but he was also afraid … because the world of grown-ups seems so hard … and sometimes it is hard … but you can easily relate to the mix of feelings he had when he thought about how it might be to grow up … a deep curiosity about what's next … a deeper sense of uncertainty about the unknown … an anticipation of the good times ahead … when you can start to do more things that feel good to you … and the impatience to get on with the comfort … and out of all the feelings … curiosity, uncertainty, anticipation, impatience … I wonder how much of which feelings you feel are just the right amounts to feel good … a lot of anticipation and just a little curiosity … or a lot of uncertainty and lots of wonderful anticipation … or huge amounts of curiosity and just a little impatience to find out how good you can feel … and to be patiently impatient while you uncertainly anticipate with an unreasonable level of certainty your ability to feel good … it's nice just to feel good now and then … now and later.…

Confusion techniques are by their very nature more demanding of the clinician's hypnotic talents than are simpler, more direct approaches. Their potential for greater disruption to clients' usual experience of themselves, though, is a compelling rationale for wanting to employ these methods when the context supports their use.

Other Hypnotic Approaches to Pain Relief

A considerable number of other direct and indirect strategies can be employed to facilitate analgesia (Erickson in Rossi, 1980; Jensen, 2011a; Patterson, 2010; Weitzenhoffer, 2000; Zeig & Geary, 2001), including the following:

1. Amnesia, in which clients are offered suggestions to forget having had pain, at least at times. This can interrupt the experience of the pain being continuous and thus paves the way for suggesting intermittent and increasing periods of comfort as far as clients can remember (Erickson in Rossi, 1980; Patterson, 2010)
2. Gradual diminution, in which suggestions are offered that the discomfort decreases slowly over some specific span of time (Jensen, 2011a, 2011b)
3. Pseudo-orientation in time, in which clients are age progressed to a period postrecovery (Erickson, 1954)
4. Time distortion, in which moments of comfort can be expanded in subjective perception (Cooper & Erickson, 1959; Weitzenhoffer, 2000)
5. Regression, in which individuals are age regressed to a period that is prior to the pain's onset to recapture feelings of comfort
6. Distraction from the pain (Barabasz & Watkins, 2005)

Twelve distinct yet overlapping clinical hypnosis strategies for helping reduce pain and suffering have now been presented. These need to be applied skillfully, of course, and they need to be regularly reinforced by clients with practice. Recording the session for clients and giving the recording to them for later review is virtually always a good idea. So is teaching them some kind of formal self-hypnosis procedure that can be used independently anywhere (Yapko, 2002).

VIEWING THE CASE OF VICKI: HYPNOSIS WITH A TERMINAL CANCER PATIENT

With this fourth edition of *Trancework*, you have been given a DVD of an unedited single-session intervention for pain relief with a woman named Vicki. You have also been given Internet access to a full, unedited transcript of the session with analysis and commentary to guide your viewing of the session. You might have already watched the session by now, but whether you have or haven't, now would be an exceptionally good time to view it and watch the flow of the session with a more experienced eye. Vicki is only 42, and her troubled history provides a compelling backdrop to her current tragic circumstances. She has cancer and reports that the doctors don't know where the primary site is. She has it in her brain, lungs, bones, and adrenal glands, and tumors are now popping up in multiple places around her body. She seeks hypnosis to be as comfortable as possible in the little time she has left to live, wanting to avoid drugs, which only make her sleep, understandably leading her to say, "I don't want to sleep my time away." This is a one-time meeting, and the stakes are high.

Notice Vicki's language and how she describes her experience of her pain. Notice her expectations, her less than ideal previous experience with hypnosis, her openness with me, her anger with her medical doctors who missed the chance for early diagnosis and treatment because of their prejudices about her past emotional instability, her ability to adapt, her sadness with her family, and her struggling to cope with the ravaging effects of the cancer on her brain and body. This session is as dramatic as sessions can be, with life and death literally hanging in the balance.

You may notice something else: I never used the word *pain* during our session, even though that's why she was there. The word pain has a strong negative emotional attachment to it, for it represents both a physical condition and an emotionally charged experience that is most unpleasant. Use of the word pain, therefore, should be avoided whenever possible. You can substitute less charged words like *pressure, discomfort*, or *uncomfortable sensation* in place of the word pain.

Vicki's session is inspirational. She bitterly complains about doctors not listening to her and the ultimate price she will pay for that neglect. Ironically, she has now been heard by more doctors than she could have possibly imagined. She continues to teach the most important lessons we as clinicians can hope to learn: the importance of listening, the need to respond to people rather than their diagnostic labels, and the incalculable value of kindness and compassion in striving to help someone suffer less.

CONCLUSION AND FUTURE POSSIBILITIES

This chapter provided a brief overview of the subject of pain management with hypnosis. Hopefully, the point came through over and over again that treating pain with hypnosis is a complex, sophisticated, powerful, and rewarding endeavor. There are different types of pain, each suggesting a different style of medical treatment and each requiring a different hypnotic approach (Feldman, 2009; Jensen, 2011a, 2011b; Patterson, 2010).

The evolving genetic and neurosciences see new biological treatments on the horizon. These include a possible gene therapy in which chronic pain sufferers will be injected with genes encoding for natural painkillers, new applications of transmagnetic stimulation (TMS) to "reroute" nerve connections, and new methods of neurofeedback to retrain the brain's processing of pain signals (Park, 2011).

The evolving neuroscience of hypnosis also holds new possibilities. Patterson and his colleagues have already been exploring another future with his innovative work on the use of virtual reality (VR) technology with pain patients (Oneal, Patterson, Soltani, Teeley, & Jensen, 2008; Patterson, 2010; Patterson, Tininenko, Schmidt, & Sharar, 2004; Patterson, Wiechman, Jensen, & Sharar, 2006). Patterson (2010) described the VR process: "The experimental

approach involved placing patients in a computer-generated three-dimensional environment in which they interacted with a simulated world around them. The operative cognitive processes involved distraction and, specifically, pulling attentional resources away from processing pain" (p. 50). Suffice it to say that the results have been quite promising and speak to how new technologies can be integrated well with the oldest technology there is for having a beneficial effect on another: a kind and meaningful word.

Integrating hypnotic analgesia with other therapeutic modalities can make for a well-balanced intervention for clients in pain, regardless of the pain's source. I have been encouraged in recent years by the number of medical and behavioral medicine practitioners discovering the viability of hypnosis as a primary tool in the comprehensive treatment of the pain patient. Working hypnotically with patients in pain can be a specialty in itself and is a most humane means for helping people cope with one of the most distressing and devastating of all human conditions.

FOR DISCUSSION

1. What do you think of the team approach to helping someone in pain? List and discuss some of the advantages and disadvantages of such an approach.
2. How can you best explain to someone that when hypnosis alleviates pain it doesn't mean the pain was psychogenic?
3. Are there times when helping someone out of pain might be a bad idea? Explain your answer.

THINGS TO DO

1. Visit some pain treatment centers in your community and see what methods they use to help their patients. Do they use hypnosis? Why or why not?
2. Design a pain treatment facility as if you had an unlimited budget. What would you want to include as essentials of your pain management program?

CHAPTER 26

HYPNOSIS ACROSS MODALITIES
Parallel Processes

One of the questions routinely asked of experts in clinical hypnosis concerns the relationship between clinical hypnosis and other experiential approaches. Clinicians ask, "How is hypnosis similar to (or different from) what I already do?" There are many, many different therapy and self-help techniques that employ relaxation, imagery, self-suggestions, the focusing and defocusing of attention, detachment, altered states, and other such experiences that seem to share some overlap with clinical hypnosis. These are just a few of the more popular ones: mindfulness (also frequently called mindful meditation), visualization, guided imagery, autogenic training (AT), some forms of yoga, and eye movement desensitization and reprocessing (EMDR).

Are these approaches simply differing forms of hypnosis, or are they distinct forms of experience in their own right? This question is easier asked than answered. The primary reason it is difficult to pin down an answer to the question, "Is this hypnosis or isn't it?" is because experiences such as these are so subjective there is no precision in either defining or measuring them. How can we take a global experience of comfort, focus, responsiveness to suggestions (whether delivered by self or another), emotional processing, and so forth and determine how much was due to suggestion and suggestibility, the contextual factors, expectancy, level of rapport, changes in the brain, and all the other relevant variables? Each approach evolves independently, developing its own conceptual framework and language, explaining its goals and methods in its own idiosyncratic manner. Thus, each experiential approach tends to think of itself as unique in its form and function, and therapeutic results are

attributed to the self-defined unique aspects of that approach. In this respect, hypnosis is—or isn't—in the eye of the beholder. How you see an approach is naturally determined by what you have been trained to see as well as what you are inclined to see. Whether you have come to think of hypnosis as existing in every form of treatment because of the inevitability of suggestions such as, "Let's do this and you will feel better," or whether you think of hypnosis as a specialized ritual that arises only in certain specific conditions, your view of hypnosis is what will ultimately determine whether you view an approach as being based in hypnosis.

In this chapter, we will again consider what defines an approach as *hypnotic* in form and function. We will go further, though, by extending the principles and methods of hypnosis into other experiential approaches, identifying how patterns of hypnosis are clearly evident in these approaches and are, arguably, the catalysts for their therapeutic effectiveness.

THE "HOLY GRAIL" OF HYPNOSIS

The search for the Holy Grail of hypnosis—the unambiguous indicator that declares "This is it!—has been ongoing forever. Here we are this far into the text, and we can still sensibly ask, What is hypnosis? From this foundational question come many other questions that are equally enigmatic: What defines an experience as hypnosis? How many hypnotically based elements of experience need be evident before declaring an experience an "official" experience of hypnosis?

As we have seen, the ambiguity of definitions of hypnosis, inevitable when attempting to define something so innately abstract, virtually precludes arriving at a universally agreed upon meaning. The phenomena of hypnosis, seemingly byproducts derived only from being in hypnosis, lose their status as uniquely hypnotically generated when the same qualities of response can be produced merely by suggesting imagining having such responses (Barber, 1969, 2000; Lynn & Green, 2011). The field of hypnosis has strived to be "special" and distinct from all others, understandably, but it is far more realistic to take the position that hypnosis goes beyond the narrow boundaries of people trying to define it in one way or another. Hypnosis can be found in places other than hypnosis.

The fact that the boundaries defining an experience as hypnosis are not very well defined leads to an easy appreciation for how hypnosis can spill over into other experiences and play an influential role in defining them. The core structures of hypnotic methods, especially *selective attention* and *suggestion,* are not unique to hypnosis. They can be found in varying degrees and in a variety of forms across many different therapeutic approaches.

Why don't these parallel methodologies recognize the role of hypnosis in their procedures? Why is it, as Ernest Rossi insightfully commented years ago when describing hypnosis as the roots of psychotherapy, that "the children don't

recognize their parents" (Yapko & Rossi, Decembr 11, 2009)? In some instances it's simply because of misconceptions about hypnosis (e.g., "hypnosis involves telling people what to do and in our approach we don't do that"), and in other instances it's because of a lack of exposure to the literature of hypnosis as a parallel methodology evolves along its own lines (e.g., "I never realized that a recommendation to detach from your thoughts to better evaluate them is actually a suggestion for dissociation").

REVISITING DOING HYPNOSIS VERSUS BEING HYPNOTIC

Previously, I made the distinction, though hardly a precise one, between *doing* hypnosis and *being* hypnotic. Doing hypnosis—that is, carrying out the formality of an induction procedure—isn't essential to producing so-called hypnotic phenomena. Being hypnotic can elicit the same phenomena through less obvious means.

What does it mean to be hypnotic? I have offered many possibilities already that are spread across these pages. However, to provide a direct answer to the direct question, I can say that to be hypnotic means many things:

- Being aware of yourself as a communicator, recognizing that you cannot not communicate and that your every word, gesture, and facial expression invite a response from others
- Recognizing that suggestion and influence are inevitable in every interpersonal context, but especially so in the context of therapy where patterns of influence are applied, intentionally or not, for goal-oriented and presumably benevolent purposes
- Using one's demeanor to encourage presence and comfort, one's voice (i.e., cadence and tempo) to soothe and focus, one's words to engage and inspire, and the context to amplify and catalyze one's therapeutic intentions
- Inviting experiential, multilevel responses

Knowing that the capacity to be hypnotic exists in any interaction, it becomes even easier to identify the hypnosis in other approaches, especially those that are more experientially based.

EXPERIENTIAL LEARNING IN THERAPY

It has been said that there are currently over 400 different forms of psychotherapy (Consoli & Jester, 2005). It has also been pointed out that the differences between approaches are greatly exaggerated and that, in fact, when comparing and contrasting approaches, it turns out that approaches are generally

much more similar than dissimilar (Brown, 2010; Lambert, 1992; Lambert & Simon, 2010). The so-called common factors viewpoint about the essentials of sound clinical practice across many different treatment models has been advanced and well recognized.

The field of therapy has gone through many, many changes over the years. These changes have involved expansions, revisions, self-explorations, and especially a transition toward empiricism in response to the question, "Does this approach to psychotherapy work?" and its corollary, "How do we know for sure?" But therapy has also gone through one more major transition that has had a powerful impact: a change in emphasis from insight as the primary catalyst for change to experience as the vehicle of meaningful learning.

There is good reason to encourage experiential learning. As much as we may want to empower people to independently engage in insightful self-exploration and self-discovery, in the context of therapy where often we are trying to teach specific skills for improved problem solving and better coping, the evidence suggests that people will often do better when they are guided through a structured learning experience. As psychologist Richard Mayer (2004) wrote in summarizing this research:

> … Guided discovery is generally more effective than pure discovery in promoting learning and transfer to new problems. Apparently, some students do not learn the rule or principle under pure discovery methods, so some appropriate amount of guidance is required to help students meet two important criteria for active learning—a) activating or constructing appropriate knowledge to be used for making sense of new incoming information and b) integrating new incoming information with an appropriate knowledge base. (p. 15)

Therapy generally encourages a blending of the two: guided discovery exposes clients to the general domain of problem solving as well as specific possibilities; and pure discovery takes place when clients are skillfully positioned to find their own solutions. *Owning* the solution, that is, feeling empowered to solve one's own problems, is considered desirable by virtually all psychotherapeutic methods. The clinician's skill is found in how well he or she positions clients to actually do so.

Therapists seem to have embraced the value of guided experiential learning; most clinicians routinely make use of homework assignments, for example. These may involve skill-building tasks, recommended readings (i.e., bibliotherapy), behavioral experiments, self-expressive activities (e.g., journaling), and other such experiential methods.

GUIDED EXPERIENTIAL PROCESSES AND HYPNOSIS

Therapists have also embraced the kinds of structured guided experiences that are identical in both form and intent to hypnosis, such as mindfulness

and guided imagery. These are procedures that typically involve suggestions for the following:

- Focusing attention
- Paying increased attention to internal events and processes (such as one's breathing or mental imagery)
- Detaching from usual awareness
- Developing relaxation
- Becoming absorbed in a goal-oriented process
- Evolving automatic, nonvolitional responses to suggested experiences
- Transferring new insights and knowledge gained from the experience into desirable contexts
- Reorienting to a "usual" state of mind with a clear sense something important and beneficial related to the therapeutic goal has occurred

These characteristics are found in different ratios across different approaches and with different philosophies and rationales for doing so. But these are all suggested experiences, and all are core components of the differing methods. Typically, varying approaches emphasize the content of their methods—what type of person or problem the technique is for, what the process aims to do, what the recommended procedure is, and so on. Of course, hypnosis can be content oriented as well (as typically found in scripted approaches), but the real strength of hypnosis is found in the process, that is, the how of skillfully structuring interactions to maximize the effects of all the various stages of therapy and functions of suggestion articulated already. Thus, learning and mastering the art of clinical hypnosis holds the potential to enhance any experientially based approach.

MINDFULNESS AND HYPNOSIS: SUGGESTING AWARENESS AND EVEN ENLIGHTENMENT

To amplify the point about the inevitability of suggestions in experiential processes, and therefore the relevance of client suggestibility as well as the power of the context in shaping clinical response, it would be helpful to explore an example in some detail. Mindfulness is an ideal approach to use for these purposes. However, one could likely take any experiential process, regardless of whatever treatment model it is embedded within, and discover similar hypnotic elements.

Mindfulness is a popular experiential approach that has attracted a great deal of attention from health-care professionals, especially mental health professionals. The attention appears to be well deserved because, to date, the therapeutic merits of mindfulness have received considerable support in the scientific literature. I have explored mindfulness and its relationship to hypnosis in much greater detail in my book *Mindfulness and Hypnosis: The Power of Suggestion to Transform Experience* (Yapko, 2011b).

Consider these two definitions or characterizations of mindfulness:

> "Mindfulness is paying attention, on purpose, in the present moment, as if your life depended on it, non-judgmentally" (Kabat-Zinn, 2006a).
>
> "Being mindful simply means having good control over your attention: you can place your attention wherever you want and it stays there; when you want to shift it to something else, you can" (Hanson & Mendius, 2009, p. 177).

Paying attention and having good control over your attention are shared goals of both hypnosis and mindfulness—as well as just about every other therapeutic approach you can name. Both rely on suggestions to encourage self-exploration and develop a greater focus, whether on the immediacy of experience (i.e., "being present") or on something else (e.g., images associated with being someplace soothing). Both emphasize acceptance as an outgrowth of self-awareness, although hypnosis practitioners are more likely to use the term *utilization* of what is rather than or in addition to acceptance.

Mindfulness encourages a quiet, accepting, compassionate focus in connecting to one's higher self. To practice hypnosis in a clinical context is to also encourage a quiet, gentle focus that creates an opportunity to explore oneself and discover hidden talents and potentials, such as the ability to transform an image into a deliberate physical response, such as an anesthetized body part. Hypnosis, depending how it is structured, can be an experience of greater sensory awareness, structurally identical to that of many mindfulness exercises. One mindfulness expert has estimated that there are 80,000 different meditations; predictably, where they will differ to the greatest extent is in their associated content.

Different Hypnoses, Different Mindfulnesses

Mindfulness applied in a clinical context for the purpose of changing someone is quite different than mindfulness for spiritual enlightenment. These differences have not yet been well elaborated, in my view, although I have initiated the dialogue with my book *Mindfulness and Hypnosis* (Yapko, 2011b). As a direct consequence, the guided meditations that mindfulness practitioners provide are structured and delivered in ways that greatly overlap hypnosis. In interviewing many mindfulness experts for my book, I regularly encountered the popular mythology that mindfulness imposes nothing and simply elicits the "awakening" or the lifting of "the veil of illusion." The sorely outdated, stereotypical, and entirely incorrect view of hypnosis advanced by these experts was that, in hypnosis, you are imposing your will on clients by actively suggesting, even demanding, they respond in some compliant way. Hypnosis is thus erroneously viewed as a means of usurping clients' will, leading them away from self-awareness and, with it, greater self-acceptance. This explains much of the negative attitude about hypnosis I encountered in my research. Truthfully, if I

thought hypnosis usurped the will of clients when I'm striving to help empower them, I'd have a bad attitude, too. But this represents how an approach develops that is deeply rooted in hypnotic principles and patterns, as you will see shortly, that has little or no awareness of itself as a suggestive methodology. Nevertheless, what makes clinical hypnosis and guided mindfulness meditations (GMMs) equally therapeutically valuable and inextricably entwined with each other is their experiential nature and the empowerment that comes directly from such absorbing experiences. In this frenzied, frenetic, work-ever-harder world, taking time to stop and focus can literally be lifesaving.

The Content and Process of Mindfulness

Mindfulness strategies typically focus on the breath as the vehicle for staying connected to oneself in the moment. When individuals are encouraged to focus on their breathing, as the basis for building a deeper experience of absorption, the content of the approach is the breath. Clients become aware of the sensory details associated with breathing, such as the rate of inhaling and exhaling, the volume of breath taken in and released, the location of the breath (whether at the nostrils or in the chest or diaphragm), and the temperature of the breath. These sensory details can easily occupy their awareness as it flitters from one sensory experience to another, all a part of "being in the moment."

At the process level, though, individuals are encouraged to focus attention on an internal experience. The content is what you focus on, and this naturally varies from technique to technique: people can focus internally on the taste and texture of food in their mouth if they want to learn to "eat mindfully"; they can focus internally on emotions that surface in response to different images or thoughts that pass through awareness if they want to become more "emotionally present"; or they can focus internally on sensations changing in location or intensity if they strive to better "manage pain mindfully." What individuals focus on is vitally important, for it is unquestionably true that what you focus on defines the quality of your experience.

Ronald Siegel, author of *The Mindfulness Solution* (2010), candidly described how some clients react poorly to mindfulness exercises. He gave as an example the person who, instructed by the therapist to focus on silence, suffered a panic attack only 3 minutes into the process. Similarly, there are individuals with a history of trauma who, when encouraged to close their eyes and "go inside," panic and bolt out of the chair. As soon as quiet or an internal focus is suggested, some people immediately return to and get overwhelmed by their source of distress, such as a traumatic episode. As clinicians we can help people "stay with" and "work through" such reactions, and they can become therapeutically valuable. In fact, many therapists work in just this way. If you think about it, though, these are often preventable reactions. I would suggest that the less therapists are bound to specific techniques and the more they

understand the process and content of the techniques they intend to use, the better they can tailor their approaches to the unique needs of the individuals they treat.

If we're going to focus people on developing a mindful orientation, a potentially valuable intervention, then we need to be explicit about the nature of the process of mindfulness, providing a greater insight into its methods so we don't foster rigidity in either ourselves or our clients. For example, we need to be clear that if and when you ring a Tibetan meditation bell to encourage "a sense of arriving" or to signal the start (or end) of a meditative period, the bell is meant to be an associative cue that signals something is expected of the client or student. Thus, the bell is only the content. You could just as easily substitute a finger snap, a Beatles riff, or any other auditory stimulus that clients accept as a valid signal for shifting and engaging attention. It's not the bell that's significant; rather, what is significant is that a signal is established suggesting to listeners that something important is about to occur. The signal further suggests that they pay attention in the manner of the others present or in the manner modeled by the therapist as the "right" or ideal way to respond. The bell offers what is called, in hypnotic terms, an *implied directive*, an indirect suggestion about what clients should do if they are to respond appropriately. In this respect, mindfulness is like every other intervention: clients have to be instructed in the concepts, terminology, rituals, and methods of whatever therapy they subscribe to. Whether it's the willingness to lie down on a couch with the analyst sitting behind you while you describe your childhood or dreams or whether it's keeping a Daily Thought Record and catching your cognitive distortions, therapy is a process of absorbing clients in the rules and rituals of a perspective that is promised to help. The more invested people are in following those rules and rituals, the more likely they are to benefit from them: there is evidence that the more demands you make on the client, the better the client's results (Kirsch, 2010).

Here's another example of content and process and wondering what works: the "Eating Meditation" is a common mindfulness meditation strategy used to encourage sensory awareness, by those striving to teach "mindful eating" (Hanh & Cheung, 2010; Kabat-Zinn, 2002). In this exercise, individuals are given a raisin or an apple to meditate upon, using the raisin or apple to develop a greater awareness for the many sensations they might notice with a given food stimulus. Focusing on the content associated with the raisin or apple, they can focus on such variables as its texture, smell, and taste. To focus on a raisin is an excellent exercise in striving to maintain a narrow yet comprehensive focus on a specific stimulus for some prescribed length of time, perhaps 30 minutes or more. But the raisin is mere content. It wouldn't matter if you used a raisin, an asparagus spear, or a piece of saltwater taffy. Just focusing individuals on the various sensations associated with having something edible stay in their mouth without carrying out the usual patterns of placing food in their mouth and then chewing and swallowing it will have a noticeable

and probably therapeutic effect. Is it the increased sensory awareness that is therapeutic, or is it the interruption of a usual behavioral sequence? Is it meditating on the raisin that is therapeutic in and of itself, or is it the empowering realization in response to the suggestion that individuals' eating behavior can change followed by a direct experience of then deliberately and proactively changing it?

As long as the procedure has face validity—that is, clients accept it as a plausible procedure—then the experiential process can successfully get under way. As research in the domain of hypnosis has already suggested, what makes an induction effective is clients believing it is effective. That's why there are virtually an unlimited number of different types of inductions, and they all have the potential to work well with someone.

STAGES OF HYPNOTIC INTERACTION IN EXPERIENTIAL APPROACHES

Hypnotic interaction can be thought of as taking place in at least seven general stages:

1. Preparing clients (psychoeducation about the experiential process, building expectancy for its likely success, and securing from clients an intent to cooperate with its aims and methods)
2. Orienting to the experience and securing attentional absorption
3. Hypnotic induction or mindful focusing (building focus, selective attention)
4. Building a response set; that is, an increased tendency to respond positively as the session progresses (building a momentum of responsiveness toward therapeutic objectives resulting in an intensification or deepening of the experience)
5. Therapeutic utilization (Suggestions for Change); that is, suggestions given directly or indirectly with an intent to alter clients' experience in some presumably therapeutically beneficial way (based on an agreed upon treatment plan)
6. Contextualization of new behaviors and perceptions; that is, establishing a "link" or association between new experiences in the session and their relevance to other parts of individuals' lives (the primary function of the posthypnotic suggestion in hypnosis)
7. Disengagement and reorientation (guiding people out of the experience and into "usual" awareness)

No matter who is conducting the experiential process, whether a hypnotist, an enlightened spiritual master, or some other facilitator of structured experiences, these stages and associated intents are an inevitable part of the process.

A GUIDED MINDFUL MEDITATION TRANSCRIPT: CHARACTERIZING EMBEDDED SUGGESTION STRUCTURES

Having said all this, we can now turn our attention to the challenge of highlighting these points directly. I am going to provide key sections (the full transcripts would be too long) of the verbatim transcripts of a guided mindful meditation session conducted by a leading expert in mindfulness and Buddhist philosophy, Jon Kabat-Zinn. He is author of *Full Catastrophe Living* (1990), *Coming to Our Senses* (2006b), and *Wherever You Go, There You Are* (2005) and is widely acknowledged as the person most responsible for bringing Eastern meditation practices to Western Medicine.

Jon Kabat-Zinn (2007): "Holding the Moment in Awareness"

The following transcript is of a live guided meditation conducted during a lecture on mindful meditation at Google on October 11, 2007. The presentation in its entirety is available online at *YouTube* (www.youtube.com; type in the key words "Google" and "Kabat-Zinn").

Stage 1: Preparing the Clients Following the psychoeducational presentation about the merits of meditation and the benefits to be derived from its practice, Kabat-Zinn conducted a live guided meditation process with the group members in attendance.

Kabat-Zinn: So, let's see if we can *tune into now* for no other reason than just for fun … not to get anywhere, (or) to be more relaxed, (or) to become a great meditator, (or) to break through some problems that you're having … but to see if you can hold this moment in awareness …	*Analysis and Commentary:* A direct suggestion to establish a frame for the experience to come: an indirect suggestion to detach (dissociate) from having any other goals beyond meeting the challenge to be aware in the moment. A direct suggestion this experience will be "fun" to enlist cooperation.

Stage 2: Orienting the Clients to the Experience Kabat-Zinn described the fact that there are multiple streams of sensory awareness available to notice. He introduces the term *proprioception* as a means of framing the automaticity of perception and then the automaticity of bodily functions such as breathing.

Kabat-Zinn: … If breathing depended upon the conscious mind … we'd all be dead already … "Well, I got busy, forgot, oh yeah,	*Analysis and Commentary:* A direct suggestion that there is an unconscious mind that can perform a variety of functions admirably, in

I'm supposed to breathe." Luckily … the design of the nervous system is much too clever to leave that to conscious control … what's being suggested is, [let's] see if we can drop in on the sensations of breathing without fiddling with the breathing at all, it knows how to do it really well, much better than you …

some cases even more efficiently than the conscious mind. This provides a direct motivation to evolve more automatic processes, such as the reflexive mindful awareness promised to develop with the regular practice of meditation. Kabat-Zinn offers an indirect suggestion to orient to the normal dissociation of conscious and unconscious functions.

Stage 3: Hypnotic Induction or Mindful Focusing The focus now shifts from the general orientation and rationale for the session to a narrowing of attention to the breath.

Kabat-Zinn: … So see if you can just feel yourself breathing … sit … [in an] elevated and erect position that embodies dignity … [to] meet this moment in its fullness with alertness … let's see if we can feel the breath, not think about the breath … moving in and out of the body as if we were approaching a shy animal sunning itself on a tree stump in a clearing in a forest, we want to approach [it] gently …

Analysis and Commentary: A direct suggestion to focus on breathing and a direct and content oriented suggestion as to how to sit properly. A direct suggestion to separate (dissociate) feeling from thinking about the breath. A metaphor (indirect suggestion) of a "shy animal" to engender a gentleness toward oneself as one engages in the process. An indirect suggestion to think of the body as detached by comparing it to an animal in the forest to be approached cautiously.

Stage 4: Building a Response Set The purpose of the response set is to increase responsiveness as the experiential process unfolds over time. In this phase, suggestions are offered to intensify focus and deepen absorption in the process.

Kabat-Zinn: … And if you'd like to concentrate more, focus on the abdomen or wherever the sensations are most vivid, I invite you to close your eyes if you care to … and just ride, surf, and the feeling the sensations of the breath moving in and out of your body, moment, by moment by moment … and let

Analysis and Commentary: A direct, permissive, content-oriented suggestion to focus on the abdomen or find some other place on which to focus. A process suggestion to focus on discovering where unspecified sensations are vivid. A permissive suggestion for eye closure. An indirect suggestion to give substance

everything else going on in the mind, in the room sounds, everything, just be in the wings …

enough to the sensations to be able to make use of the metaphor of riding or surfing them. A direct suggestion to narrow the time frame (time distortion) to a moment to moment perception, decreasing the subjective sense of time involved in the process. A direct suggestion to dissociate an awareness for breathing from anything and everything else and a direct suggestion to relegate these to no more than a peripheral role.

Stage 5: Therapeutic Utilization (Suggestions for Change) Kabat-Zinn suggested that whether experienced or just a beginner, the mind will naturally wander; the task is to "come back to the breath over and over again." The explicitly stated goal of the session is to teach the value of awareness in the moment and the importance of holding on to that awareness across life experiences.

Kabat-Zinn: … It's not like you'll make a bad meditator because your mind is unruly, this is the nature of the mind … it's just like the Pacific Ocean … at its most tumultuous if you learn to drop down 20–30 feet under the water there's just gentle calmness … and it's the same with the mind. The surface of the mind can be very agitated, embroiled in thought and emotion, but awareness itself is like the depths …

Analysis and Commentary: A direct suggestion to reframe the mind as "unruly" as a means of accepting and utilizing the mind's natural tendencies rather than fighting against them. This de-pathologizes and reframes such wanderings as normal. An indirect suggestion through metaphor to visualize the mind as like the ocean in order to offer the direct suggestion that there can be surface turbulence and deep calm simultaneously. An indirect suggestion (called an implied directive) to first create then go to a special place (i.e., into the depths of oneself) to find a sense of calm in difficult circumstances. This is a perfect parallel to the "safe place" technique many therapists routinely employ with anxious and traumatized clients.

Stage 6: Contextualization Kabat-Zinn suggests a focused and immediate awareness for breathing, an appreciation for the inevitability of mindlessness and the value of mindfulness, finding comfort in the depth of oneself, and integrating a sense of gentle compassion toward the self.

Kabat-Zinn: … If [the mind] wanders 10,000 times, you know what's on your mind 10,000 times, and without judging condemning, forcing, blaming, just come back to this moment, this breath … with a certain kind of tenderness as a radical act of love and kindness just towards yourself … wherever you are … and the meditation practice winds up doing you much more than you are doing the meditation practice and the world and everybody and everything becomes your teacher …

Analysis and Commentary: A direct suggestion to reframe a wandering mind as an opportunity for awareness of "what's on your mind." Direct suggestions to accept the mind's preoccupations without any negative, critical judgments, indirectly suggesting dissociating from what is commonly termed the "inner critic." Direct suggestions to re-direct awareness to the breath as a means of regaining a sense of calm. Direct suggestions to associate feelings of love and kindness to one's internal experience, termed an *affective reassociation* in hypnosis terminology. Direct suggestion to globally apply these skills wherever individuals happen to be rather than suggesting they be tied to a specific place or context. Typically, such broadly worded posthypnotic suggestions are weaker in effect than more precisely worded posthypnotic suggestions for specific responses in particular contexts. A direct suggestion that responses will become automatic and effortless in time and with practice, establishing a motivation to practice and an expectancy that practice will eventually pay off. A direct suggestion that meditation will help establish a mind-set that anyone and anything can be a teacher, thereby defining oneself as a student: open, aware, and curious rather than closed, restricted, and

judgmental. This is another indirect suggestion for affective reassociation, encouraging a calmer, detached, and more accepting response to life experiences, whatever they may be.

Stage 7: Disengagement and Reorientation In this last stage of the process, Kabat-Zinn brings people back to a more externally oriented awareness of themselves and the context. He suggests that the formal experience may be over, but striving for awareness can be a lifelong commitment.

Kabat-Zinn: [Meditation bell rings] … Now I'd like to invite you, if your eyes are closed, to allow your eyes to open … while maintaining the same quality of awareness … even as you turn your head or shift your body or stretch … so although the formal meditation practice, in some sense comes to an end, and has to, the real meditation practice never comes to an end, it's your life … It's no more at an end than your breathing …

Analysis and Commentary: A permissive, direct suggestion to open the eyes. A direct suggestion to maintain the same quality of awareness despite the transition from closed to open eyes. An indirect suggestion to dissociate awareness from physical reorientation. A direct suggestion that the formal experience is now over and an indirect suggestion to absorb the idea that awareness is a lifelong opportunity; as long as you are able to breathe, you are able to meditate and be aware, a deliberate blurring of the lines between meditation and life itself to define meditation as essential to living well.

LET SUGGESTION BE YOUR GUIDE

This transcript provides compelling evidence that a guided mindful meditation must be viewed as a highly suggestive process. Furthermore, it is an interpersonal process with clearly delineated roles of guide/therapist and student/client. It doesn't and shouldn't diminish the merits of mindfulness to acknowledge the role of suggestion in the process. On the contrary, the awareness and sense of empowerment that arises during mindfulness processes speaks for itself in terms of its therapeutic value. An awareness of the hypnotic language and the hypnotic phenomena inevitably embedded within these processes can only serve to add to that value.

ARE NONVERBAL EXPERIENTIAL PROCESSES HYPNOSIS BASED?

As we have seen, any process that encourages selective attention and employs suggestions—whether through words or gestures—to guide someone else's experience toward some therapeutic goal will inevitably contain hypnotic elements. What about nonverbal approaches as a vehicle of treatment? Certainly the approach is markedly different when a steady stream of verbage, typical in clinical hypnosis sessions, is absent from the process. Can hypnosis be done, for example, with someone who is deaf?

Milton Erickson's Pantomime Technique and Working With the Deaf

It is said that "necessity is the mother of invention." When Erickson was giving a presentation to a professional group in Mexico in 1959, he was asked to conduct a clinical demonstration with a woman who spoke no English. Erickson did not speak Spanish. He had occasionally made use of brief pantomime gestures and used varying facial expressions to facilitate hypnosis sessions before, but these had always served as enhancers to his verbal suggestions. Now, he was going to conduct a demonstration with only nonverbal suggestions.

Erickson (1964b) described his innovative, successful procedure in considerable detail. He described similarly successful episodes while teaching in Venezuela in 1961. He also described utilizing this approach with deaf individuals.

The literature on the use of hypnosis with the deaf has been relatively small. For many who practice only a verbal hypnosis, it is understandably daunting to strive to do hypnosis relying entirely on nonverbal methods. Does deafness reduce hypnotic responsiveness? As common sense would predict, apparently not. Using the Stanford Hypnotic Susceptibility Scale, Form C (SHSS:C), Isenberg and Matthews (1995) compared the hypnotic responsiveness of deaf and hearing subjects, all of whom were given the suggestions through sign language. Hypnotizability scores between hearing and deaf subjects showed no significant difference.

Some hypnosis experts have ventured successfully into this territory. Gravitz (1981) presented a case involving nonverbal suggestions with a deaf and brain-damaged patient. Bowman and Coons (1990) reported on a case involving a deaf mute. Kohen, Mann-Rinehart, Schmitz, and Wills (1998) provided two case reports on applying hypnosis with deaf children. Isenberg and Matthews (1991) provided some additional insights into the process of working hypnotically with the deaf through their comparisons of doing hypnosis with hearing and deaf subjects.

What has not been studied yet are the neurological implications of deafness on hypnotic responsiveness. How are suggestions given in visual form, such as through pantomime or sign language, processed in the brain compared

with verbal suggestions? Presumably, different parts of the brain will be activated when processing nonverbal versus verbal suggestions, but the implications for forming and delivering suggestions designed to be therapeutic are currently unknown.

EMDR and Hypnosis

Eye Movement Desensitization and Reprocessing (EMDR) is a predominantly nonverbal approach to therapeutic intervention developed by psychologist Francine Shapiro (1989a, 1989b). EMDR has received considerable empirical support for its effectiveness, particularly with trauma and PTSD in combat veterans and assault victims but also with anxiety disorders (especially phobias and panic disorder), depression, and even phantom limb pain (Shapiro, 2001). Shapiro described EMDR as a catalyst for learning:

> There is a split between what [clients] want to do and what they can do; between the possibilities available and their ability to perceive and act upon them. The EMDR clinician must therefore identify the events that have been dysfunctionally stored and are stunting and coloring the client's present perceptions and assist in processing them. Essentially, EMDR facilitates learning on multidimensional emotional, cognitive, and physiological levels. (p. 4)

The EMDR approach is an eight-stage approach that has as its foundational premise the notion that incompletely processed memories are at the heart of clients' difficulties. "The model regards most pathologies as derived from earlier life experiences that set in motion a continued pattern of affect, behavior, cognitions and consequent identity structures. The pathological structure is inherent within the static, insufficiently processed information stored at the time of the disturbing event" (Shapiro, 2001, pp. 16–17).

Psychologist Stephen Gilligan (2001) described clients' sense of being "stuck" this way:

> [EMDR] rests on the assumption that as the experiences of life flow through a person, an innate psychophysiological capacity exists for processing, transforming, and integrating each of these experiences. Some events, however, can be so extreme and traumatizing that this innate integrative system is disturbed or overwhelmed, resulting in a "freezing" of the event-in-processing into a state-dependent form that is "stuck" in the nervous system. This creates an antagonistic state of affairs where (1) the event is trying to "process through" into a resolved or completed form while (2) the nervous system is shut down into a "neuromuscular lock" that inhibits all such integrative processing. The result is akin to driving down the freeway with one foot on the accelerator and the other on the brakes. (p. 319)

In contrast to verbal therapies, which "talk through" traumatic memories, attempting to reframe their meaning, encourage emotional release, desensitize them through exposure, and the like, EMDR employs a predominantly nonverbal methodology that can involve any sensory modality but typically emphasizes eliciting eye movements in clients who are instructed to follow a visual stimulus (usually the clinician's fingers) as it goes rapidly back and forth across their visual field while simultaneously holding in mind the most distressing aspects (the visual, cognitive, somatic, and emotional) of the trauma. Clients would be told to "just let happen whatever happens, trusting your inner healing principle to process whatever needs to be processed to a healing resolution. At the end of each 45-second cycle, [clients] would be asked to take a moment of rest before verbally reporting what was happening. Generally, he would be encouraged to 'go with that,' and a new 45-second cycle of eye tracking would ensue" (Gilligan, 2001, p. 320).

How this process works exactly is still uncertain. Shapiro (2001) developed a number of explanations, especially a presumed neurophysiological shift as dysfunctional memories are reprocessed and integrated. Does hypnosis play any role in this process? Shapiro doesn't think so. In an interview (personal communication, April 1, 2010), I asked her directly, "Does EMDR involve hypnosis?" She replied, "No, I think it's quite separate. [Brain research] shows specific differences between EMDR and hypnosis, just as hypnosis is found to be a different brain state than meditation … within EMDR you have an accelerated processing state, but I think that's quite different from the hypnotic state."

Not only does Shapiro (2001) think of hypnosis and EMDR as fundamentally unrelated, but she also is uncomfortable with the idea of integrating hypnosis with EMDR, fearing it will undermine the EMDR process. She wrote, "… Inducing deep trances during the EMDR treatment session may be contraindicated because the altered physiological state of hypnosis may not permit all the information to be processed adequately" (p. 297).

She also views the EMDR process as minimally suggestive: "We're trying as much as possible to keep the clinician out of the way. The clinician would primarily get involved (only) if processing stalls, in which case they might ask a question (or) make a comment; the idea is to simply elicit the next bit of information that would have automatically occurred if the processing was going spontaneously … just asking the question and then eliciting the eye movements seems to allow the appropriate linkups to take place" (personal communication, April 1, 2010).

How suggestive does a process need to be to be considered hypnotic? Do the principles of EMDR, explained to clients in the orientation to the treatment process, establish an expectation for the merits of the treatment? Does the explanation of the theory of dysfunctional memories, incompletely processed, directly suggest the need to explore those memories

and reprocess them? Do the suggestions to relax, focus, follow the (visual) stimulus, "go with the flow," report on expected changes, go back and do more cycles, and so on, help shape the EMDR process? Realistically, how could they not?

Is EMDR more than the sum of its suggestive elements? Certainly. Shapiro (2001) developed a highly elaborated and successful treatment that deserves positive recognition and thoughtful consideration. But the greater point here is that even a primarily nonverbal approach like EMDR can be viewed as suggestive and hypnotic. The primary argument Shapiro makes for the apparently unbridgeable gap between hypnosis and EMDR in her view is the difference in brain activity between them. There may, in fact, be some. However, as we're learning, the common denominator of hypnotic focusing methods is the shifting of attention. What varies in brain activation, surfacing as contrasts between hypnosis and other approaches (including mindfulness and EMDR), is attributable to the content of one's focus. Focusing on imagery of a nature scene will look differently on a brain scan than focusing on remembering a traumatic memory. EMDR isn't hypnosis, but it certainly shares characteristics with hypnosis.

Gilligan (2001) insightfully articulated some of these shared attributes:

> Interestingly, EMDR and Ericksonian hypnosis share a number of specific conditions, including an emphasis on developing and maintaining (1) relaxation; (2) direct experiential accessing the core experiences; (3) dual attention (i.e., simultaneously attending to the interior experiences and the outer environment; and (4) trust and guidance for the intelligence of the "ordered chaos" process to lead the way to integration (with a key suggestion to clients of "just let it happen"). Because of these similarities, EMDR and Ericksonian hypnosis can be used within the same therapy. Furthermore, their different forms make them complementary rather than redundant. (p. 327)

I think it is important to affirm that suggestion is inherent in any approach to health care. Where there is suggestion, whether verbal or nonverbal, the foundation for hypnosis exists, amplifying the need to maximize its potential for therapeutic effect.

CONCLUSION

Many of the changes associated with hypnosis and other experiential approaches surface in the domains of memory, awareness, absorption, rationality, imaginative ability, imagery, and attention. As we have come to appreciate, there are many different factors influencing the magnitude and direction of individuals' response. There is a great deal of social psychology at work in the utilization of these approaches, which can be ignored only if one is overly

attached to the idea that all such experiences are entirely within the person. If more than one person is involved in the process, whether performed live or on a recording, verbally or nonverbally, the suggestive interpersonal factors become necessary to consider. This point highlights one of the paradoxes found in the domain of experiential methods: I'm doing this process with you, but it's all about you.

FOR DISCUSSION

1. Have each member of the class bring a transcript of a therapy session, perhaps from a journal or book, to share with the rest of the class. Have each person read select quotes from the therapist's input. What kinds of suggestions are evident, regardless of the type of therapy applied?
2. How would you describe the differences between "doing hypnosis" and "being hypnotic?"
3. Are there any experiential learning processes that don't require focusing and attentional shifts? What does this imply for treatment success?

THINGS TO DO

1. Pick three therapies to research. Identify hypnotic patterns in those therapies, if you can.
2. Do the "eating meditation" described in this chapter at least a couple of times. List as many reasons as you can as to why this simple exercise might help someone develop better eating habits.

POSTSCRIPT

I don't know who originally made the observation, "The more you know, the more you know how little you know." Whoever it was, I wonder if he or she was talking about hypnosis at the time. Well, probably not. But it holds true for the study of clinical hypnosis nonetheless. I hope that by the time you reach this postscript you have discovered the enrichment and empowerment that clinical hypnosis can provide in the service of improving the quality of human life. And I hope you have also discovered the complexities associated with using hypnosis skillfully, making ongoing study and practice a welcome necessity in your professional life.

THE NEXT STEP

One of the most frustrating things to people in the field of clinical hypnosis is that people with far less education in hypnosis than this book gives are engaged in providing services to the public that they are not qualified to provide. All I can do about this issue is appeal to each person to get the education and credentials it takes to practice responsibly. It's a vitally important next step in taking seriously the responsibilities associated with providing health care to people.

A second source of frustration to those in the field of clinical hypnosis lies in the observation that many people take courses in hypnosis and then, when the course is over, the skills they started to acquire are not immediately used and soon fade into the past. The more hypnosis seems removed from mainstream practice, the easier it is to abandon. I hope through your learning process that you are able to see not only elements of hypnotic experience all around you but also their immediate relevance to every clinical interaction. My goal was not to transform readers of this text into "official hypnotists." Rather, my goal has been to provide you with an introduction to a dynamic and evolving field that emphasizes concepts and techniques that can significantly expand the range of both your communication and clinical skills. Even

if you never formally induce hypnosis again in your life, my guess is that you'll reflexively think twice before saying something like, "Try not to think about what's bothering you."

From this introduction to the field, I hope that you are sufficiently intrigued by the range of possibilities hypnosis has to offer to want to continue developing your skills with it. There are many ways to take that next step.

As you've seen from the extensive list of references throughout this book, representing only a fraction of the available literature, there are more books and articles published on the subject of clinical hypnosis than any of us can read in a lifetime, and every day the list of publications grows. Staying current with the literature is a valuable way of staying connected to the evolution of the field. The sources listed in this book can provide you with a starting point for meaningful reading, and, of course, the bibliography in each reference can provide further sources for learning.

Getting connected to other professionals who share a common interest in hypnosis is another wonderful way of staying current with the field as it continues to evolve. There are organizations for professionals all over the world, and information about some of these is contained in Appendix A. Many of them publish scientific journals dedicated to hypnosis research, and some of these are also listed in Appendix A.

CLOSURE

In preparing this fourth edition, I still emphasize clinical artistry in hypnosis, obviously, but I also emphasize the value of clinical research in informing and shaping artistry. There is so much more to say now about clinical hypnosis than ever before. This made it all the more difficult for me to decide what to include. I frequently found myself wanting to say more about each of the topics presented but felt obligated to preserve this text's integrity as an introductory one.

There is much more to learn about the human mind, personality, communication, and the potentials of clinical hypnosis to enhance the human condition. Our current understandings in these domains are ever expanding, and there appears to be no upper limit as to how much more can eventually be known. I look forward with curiosity and hope to all that is possible.

APPENDIX A: HYPNOSIS ORGANIZATIONS AND JOURNALS FOR PROFESSIONALS

AMERICAN PSYCHOLOGICAL ASSOCIATION, DIVISION 30, THE SOCIETY OF PSYCHOLOGICAL HYPNOSIS

The American Psychological Association (APA) is the national organization for psychologists in America, with a large membership well exceeding 100,000 members. It is divided into dozens of components, each with a specialized focus within the domain of psychology. Division 30 is called the Society of Psychological Hypnosis. Once a member of APA, you are eligible to join the component division branches of your choice. When you join Division 30, you will receive an informative bulletin three times per year about events within the field in general and within Division 30 in particular. Clinical issues, news updates, literature reviews, and other informative and helpful information are included. Furthermore, at the large annual meetings of APA, the Society of Psychological Hypnosis holds specialized programs with prominent members sharing their latest research and clinical insights. For membership information, you can contact the APA directly.

Website
www.apa.org

For Division 30 information write:

The American Psychological Association
P.S.O./Division 30
750 First Street NE
Washington, DC 20002-4242
Phone numbers in the United States: (800) 374-2721; (202) 336-5500

AMERICAN SOCIETY OF CLINICAL HYPNOSIS

The American Society of Clinical Hypnosis (ASCH) is the largest of the national professional hypnosis societies in the world. ASCH holds smaller, more topically focused regional workshops several times a year around the United States and a large annual meeting with an impressive array of topics and presenters. ASCH also has component branches in most of the major cities across the United States. Components vary in their level of local activity. Many hold monthly meetings and annual workshops.

Website: www.asch.net
E-mail: info@asch.net
Journal: *American Journal of Clinical Hypnosis* (*AJCH*)—published quarterly and included with membership in the organization along with a quarterly newsletter

For membership information write:

American Society of Clinical Hypnosis
140 North Bloomingdale Road
Bloomingdale, IL 60108-1017
Phone number in the United States: (630) 980-4740

INTERNATIONAL SOCIETY OF CLINICAL HYPNOSIS

The International Society of Clinical Hypnosis (ISH), headquartered in Rome, is the umbrella organization for dozens of constituent societies all over the world. ISH holds triannual meetings, each time in a different location somewhere around the world, that feature many of the world's premier researchers and clinicians presenting their latest findings. Membership includes an informative newsletter containing articles, interviews, and conference information.

Website: www.ISH-hypnosis.org
E-mail: contact@ish-hypnosis.org
Newsletter: ISH quarterly newsletter featuring informative articles, interviews, meeting information, and constituent society activity updates is included in membership

For individual membership information write:

ISH Central Office
Via Tagliamento, 25-00198
Rome, Italy
Phone number in Rome: +39.06.8548205

SOCIETY FOR CLINICAL AND EXPERIMENTAL HYPNOSIS

The Society for Clinical and Experimental Hypnosis (SCEH) is a prominent American organization for hypnosis professionals, both clinical and research oriented, that places especially heavy emphasis on research. The *International Journal of Clinical and Experimental Hypnosis* is one of the most respected and most frequently cited scientific journals in all the behavioral sciences and reflects the high standards of SCEH. SCEH holds an annual conference that features papers, workshops, and panels on latest developments within the field, presented by many of the most well-known and respected people in the field.

Website: www.sceh.us
E-mail: info@sceh.us
Journal: *International Journal of Clinical and Experimental Hypnosis* (*IJCEH*), published quarterly and included with membership in the organization along with a quarterly newsletter

For membership information write:

Society for Clinical and Experimental Hypnosis
P.O. Box 252
Southborough, MA 01772
Phone number in the United States: (508) 598-5553

For journal subscriptions only, write to:

Taylor & Francis, LLC
325 Chestnut Street
Philadelphia, PA 19106
Phone number in the United States: (215) 625-2940

THE MILTON H. ERICKSON FOUNDATION

This organization is very active in advancing psychotherapy in all its forms but is especially dedicated to the advancement of Ericksonian approaches to hypnosis and psychotherapy. The foundation is not a society and does not have a membership. It organizes major internationally attended annual meetings, most often on Ericksonian approaches but also on brief therapy and the

evolution of psychotherapy. These meetings are held over 4 to 5 days and feature stellar faculties conducting workshops, clinical demonstrations, and other presentation formats. The foundation also holds many smaller meetings throughout the year around the United States. The foundation is the core of an international network of Erickson Institutes around the world (more than 120 to date) that also strive to advance the work of Dr. Milton Erickson. Each institute sets its own length and frequency of training. Contact the foundation for institute locations.

Website: www.erickson-foundation.org
E-mail: office@erickson-foundation.org
Newsletter: published three times a year

For general information write:

The Milton H. Erickson Foundation, Inc.
3606 N. 24th Street
Phoenix, AZ 85016-6500
Phone number in the United States: (602) 956-6196

NATIONAL PEDIATRIC HYPNOSIS TRAINING INSTITUTE

The National Pediatric Hypnosis Training Institute (NPHTI) offers state-of-the-art education and skill development for health-care professionals in the art and science of clinical hypnosis and hypnotherapy for children and adolescents.

NPHTI also provides a resource for licensed professionals and the public for:

1. The latest information in the field of pediatric clinical hypnosis for professionals and parents via its website
2. A communication hub via the NPHTI Listserve for consultation, discussion, and exchange of ideas among clinicians who have trained with them
3. A public relations resource for communication with the media

Website: www.NPHTI.org

APPENDIX B: SUPPLEMENTAL MATERIALS

There are wonderful lectures, discussions, and clinical demonstrations available on the subject of hypnosis from a variety of places. Here are some especially good sources for these professional recordings:

Michael D. Yapko, PhD: www.yapko.com
The Milton H. Erickson Foundation: www.erickson-foundation.org
Conference recordings for ASCH: Available through www.asch.net
The Hypnosis Network: www.hypnosisnetwork.com

INTERVIEWS WITH HYPNOSIS PIONEERS AND INNOVATORS

Eric Willmarth, PhD, is a psychologist from Michigan who has filmed interviews with leading figures of the field, past and present. These can be viewed at www.ewillmarth.com.

Additional interviews with leading figures of the field, past and present, can be found on my website (www.yapko.com).

A CRITICAL History of Hypnotism is a detailed book on the subject written by Saul Rosenfeld. It's available at www.historyofhypnotism.com.

APPENDIX C: FOREWORDS AND INTRODUCTIONS TO THE PREVIOUS THREE EDITIONS

FOREWORD TO THE 3RD EDITION

I attended my first hypnosis workshop more than 30 years ago, and it shines vividly in my memory. While learning the rudiments of clinical hypnosis, I was privileged to witness Dr. Erika Fromm conduct fascinating demonstrations of hypnotic phenomena including analgesia, time distortion, and age regression. At the time, there was only a modest empirical foundation for the use of hypnosis in psychotherapy, and, in the public eye, and even in some professional circles, hypnosis was as much linked with hocus pocus, flummery, charlatanism, and the like as it was associated with bona fide clinical practice. Nevertheless, I had an immediate sense that hypnosis would play an important role in my professional life, and not long after I decided to be a serious student of hypnosis. I now believe that virtually every clinical practitioner can benefit from being a student of hypnosis, and I am delighted to introduce Michael Yapko's superb sourcebook on clinical hypnosis: *Trancework: An Introduction to the Practice of Clinical Hypnosis*.

Why use hypnosis as an adjunctive procedure in the first place? Over the years I have learned that hypnosis can instigate profound transformations in

the way people think, feel, and act. Fundamental to the practice of hypnosis is the idea that deep and enduring change is possible when people are fortified by the belief that they can change and are able to integrate new ideas, perspectives, and growth-oriented experiences into their lives. When clinicians introduce hypnosis into the therapeutic relationship, it is a dramatic indication of their intention to be helpful as well as of their professional expertise and readiness to employ efficient techniques to assist clients in creating themselves anew. I have often observed how the mere expectancy of pain relief for the hurting, the balm of relaxation for the anxious, and a rosier worldview for the depressed can engender hope and forge a positive therapeutic alliance and mental set toward treatment in general. Practitioners of hypnosis are likely to be attuned to the helpful as well as the harmful effects of words and nonverbal communications and are trained to devise therapeutic suggestions that can target the cognitive and behavioral underpinnings of diverse psychological disorders and medical conditions with exquisite precision. A suggestive approach, at its best, involves an intimate collaboration with the client geared toward determining some combination of effective strategies and techniques. It is to Michael Yapko's credit that he has captured and made explicit in this volume many of the details and fine points of how effective therapy can occur when hypnosis is used as a core component of the intervention. In this way, the author achieves one of his central goals: to convey the "artistry" of hypnosis to the reader.

An emerging body of research supports the idea that hypnosis can be an effective catalyst to therapies ranging from cognitive-behavioral to psychodynamic (Barber, 1985; Lynn, Kirsch, Barabasz, Cardeña, & Patterson, 2000). Nevertheless, newcomers to hypnosis are often chary about learning hypnosis given the cultural myths that have surrounded it from the time of Mesmer, and are intimidated by the prospect of crafting inductions and suggestions and of not "doing hypnosis right." If you are such a newcomer, *Trancework* is an authoritative primer that will start you on your way. In a stepwise, logical sequence, you will learn the nuts and bolts of how to (1) establish rapport and demystify hypnosis, (2) create an hypnotic induction and devise a plethora of useful therapeutic suggestions, (3) assess responsiveness to suggestions, and (4) minimize untoward reactions to hypnotic procedures.

Readers already familiar with hypnotic procedures will appreciate the nuanced and engaging discussions of influential hypnosis theories, the role of informed consent in treatment, recent developments in cognitive neuroscience in understanding hypnosis, the pros and cons of formal versus informal hypnotic suggestibility assessment, and the advantages and disadvantages of different types of hypnotic suggestions (e.g., direct, indirect, permissive, authoritative) and manualized versus individualized treatment approaches. Novice and seasoned readers alike will appreciate the humor and wit, good advice, anecdotes, and rich case material that is the author's stock-in-trade. I found myself flipping through the pages like I was reading compelling

nonfiction, and, like some of the novels I treasure, I was disappointed when the book ended.

The title, which features the controversial term "trance," might dissuade some readers from perusing the book. That would be a mistake. As the author explains, the title is a vestige of previous editions of the book and was retained in this thoroughly updated revised to identify it with its two immensely successful predecessors. Although Yapko acknowledges that the term "trance" is obsolete, there is nothing obsolete about the contents of the book. In fact, *Trancework* brims with virtually up-to-the-minute references to research, contemporary hypnosis theories, clinical issues and techniques, and intellectually stimulating controversies and theoretical debates. The author's presentation of controversies regarding the nature of hypnosis and the role of hypnosis in creating false memories is fair to different theoretical perspectives, faithful to the empirical literature, and accessible to a wide audience.

It is evident that writing this book was a labor of love for Michael Yapko. He speaks with the authority of many years of clinical experience, shared in this and his many other excellent books. But he is also a knowledgeable, clear, and compassionate teacher who takes seriously the challenge of making the skills of hypnosis accessible to a broad audience. I heartily recommend Michael Yapko's *Trancework* to what I hope will be a growing legion of students of hypnosis around the world.

Steven Jay Lynn, PhD, ABPP
Professor of Psychology, Binghamton University, Binghamton, NY

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Barber, T. X. (1985). Hypnosuggestive procedures as catalysts for effective psychotherapies. In S.J. Lynn & J. P. Garske (Eds.), *Models and methods of psychotherapy* (pp. 333–376). Columbus, OH: Charles E. Merrill.

Lynn, S. J., Kirsch, I., Batabasz, A., Cardeña, E., & Patterson, D. (2000). Hypnosis as an empirically supported adjunctive technique: The state of the evidence. *International Journal of Clinical and Experimental Hypnosis, 48*, 343–361.

INTRODUCTION TO THE 3RD EDITION

Welcome to this new edition, the third, of *Trancework*: *An Introduction to the Practice of Clinical Hypnosis*. It has been a labor of love to prepare this new edition. Being in this field for as long as I have, it is a wonderful thing to feel even more enthusiastic about it than when I began. I hope my enthusiasm will come shining through and that you will find *Trancework* a valuable introduction to a dynamic and fascinating field.

WHAT'S NEW IN THIS EDITION

First, let me say a few words about why a new edition was necessary and what you can expect to find in this volume. The second edition of *Trancework* came out in 1990, more than a dozen years ago, and so much has happened in the field in the interim that this revision is actually quite long overdue. In fact, so much has evolved that I considered changing the title of the book simply to eliminate the use of the obsolete word "trance" just to keep in step with the times. But, the title *Trancework* is so well known within the field that it made practical sense to keep it, thereby requiring people to look beyond the title to see what's new.

So, what's new in this third edition? Two brand-new chapters have been added, as have many entirely new chapter sections spread throughout the book. Other chapters have been substantially modified, a response to the explosion of good recent studies revealing and clarifying many aspects of hypnosis. An invaluable addition to this edition is the many hundreds of reference citations provided throughout the text. For careful readers who want to be pointed in the direction of supportive research for points made or who simply want further information on a particular topic, the extensive reference sections at the end of each chapter will be welcome.

Every field has its share of distinguished contributors, and clinical hypnosis is no exception. You will be introduced to many of them in this book through special sections throughout called "Frames of Reference." In these sections, you will hear pioneers and innovators in the field of hypnosis present some of their ideas on principles and applications of hypnosis. I am pleased to have the chance to introduce you to some of the field's most influential figures.

Trancework is a textbook meant to guide your training in hypnosis. It is meant to inspire you, of course, but also to teach the skills to be effective in applying hypnosis. The chapters are filled with practical information, and at the end of almost every chapter you will be presented with "Things to Discuss" and "Things to Do." I hope and expect you will find these an invaluable part of the learning process.

WHAT'S NEW IN THE FIELD

Clinical hypnosis has been the subject of serious scientific inquiry for only about 70 years but has been the source of fascination for students of human experience for more than 2 centuries. Only in the last 2 decades, however, has hypnosis research reached a level of sophistication that offers some objective evidence for its clinical value.

Three powerful forces converged in the 1990s and continue to the present that reshaped many of our understandings of clinical hypnosis. The first of these

forces has been the growing emphasis in the field of psychotherapy on proving its worth with empirical data affirming its effectiveness. The drive for developing so-called empirically supported psychotherapies has pushed and pulled the field in different, and sometimes even contradictory, directions, taking hypnosis along with it since hypnosis is most commonly applied in the psychotherapeutic domain. A direct result is the division within the field of those who see hypnosis as a vehicle for delivering "standard" psychotherapies (e.g., cognitive-behavioral, psychodynamic) and not a therapy in its own right and those who see hypnosis as a special form of therapy reflected in the self-defining term "hypnotherapy." Regardless of one's position, the salient research questions have been, "Does hypnosis enhance treatment results?" and, "Can hypnosis correctly be considered an 'empirically supported' style of intervention?"

The second force reshaping clinical hypnosis in recent years directly and explosively collided with the first. I'm referring to the so-called repressed memory controversy. In the mid-1990s, the controversy reached its zenith, bitterly dividing the mental health profession over the presumed role of repressed memories of childhood sexual abuse as the underlying cause of a client's current symptoms. Extreme positions by "experts" dominated the field, encouraging clinicians to either believe all memories excavated in treatment through hypnosis and other suggestive memory retrieval techniques or to disbelieve all such memories as fabrications in response to untoward influence by therapists or others. (The controversy has since quieted as evidence for both/all points of view helped define an informed clinical practice.) Suddenly, hypnosis and the phenomenon of human suggestibility was in the center spotlight as experts in persuasion, interrogation, memory, trauma, and hypnosis squared off against each other, both in the journals and the tabloids, further confusing an already confused public about what it all meant. Meanwhile, each day's headlines blared a new story of some trusted figure being accused of abuse on the basis of memories recovered in hypnosis. The field of clinical hypnosis was forced to redefine itself more scientifically while directly addressing and correcting many of the common myths held about the nature of human memory and how it is affected by hypnotic procedures.

The third major force reshaping the field has been the advances in cognitive neuroscience. There is something about the experience of hypnosis that invites careful neurophysiological inquiry. After all, unusual things happen: A person has normal bodily perceptions one minute, then focuses on suggestions for experiencing a dramatic change in bodily sensations, and the next minute the person actually experiences those suggested changes. How does the mind influence the brain in hypnosis and vice versa? Newer scanning technologies, such as functional magnetic resonance imaging (fMRI), have made it possible to begin investigating the brain during hypnotic procedures in ways that simply were not possible years ago. The possibilities in this new domain of research are very exciting and may eventually help us focus our clinical efforts.

RESEARCH AND CLINICAL PRACTICE

Has a state of hypnosis, what used to popularly be called a "trance state," been identified? No, nor do people in hypnosis generally think of themselves in some unique altered state of consciousness. The use of the term "trance" to characterize the experience of hypnosis is not particularly descriptive of anything either scientifically precise or clinically relevant, so I have dropped it from the body of this volume. Instead, I will talk about the subjective experiences of hypnosis from the standpoint of the person in hypnosis and the processes of hypnosis from the standpoint of the person conducting the hypnosis session. I will generally use the term "client" to refer to the former and either "clinician" or "therapist" to refer to the latter.

With data being the new currency in the field, researchers have taken a newly ascendant position and clinicians a largely defensive one, struggling to continue to do what they feel works even if the evidence is not yet there to validate them. Clinicians understand that, no matter how much scientific data are generated, clinical practice will always require a high level of artistry. Consequently, I think it is imperative to provide you with some exposure to the scientific side of hypnosis, citing many (but only a small percentage of) the good research studies available. And I think it is even more imperative to highlight the actual skills that go into developing and delivering effective hypnotic processes. After all, no matter how much data and scientifically supported rationales you might have for a specific intervention, it means next to nothing if the client doesn't benefit from it. (Frankly, it's why I'd prefer we "validate" *therapists* rather than therapies.) As you can tell, I'm a pragmatist. My emphasis throughout this book will reflect that orientation, highlighting what is practical and effective.

Helping you evolve the artistry in both conceptualizing and applying clinical hypnosis is a primary goal of this volume, especially in light of recent clinical controversies and the demands of modern clinical practice in an age of accountability. I hope you will enjoy learning both the art and science of clinical hypnosis. And I especially hope you will discover both the personal and professional enrichments as well as the many benefits to your clients when you integrate clinical hypnosis into your practice.

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FOREWORD TO THE 2ND EDITION

Although I am not a practitioner of the Ericksonian approach or a strategic therapist and hold different opinions on aspects of hypnotism from Michael

Yapko, I believe I can correctly state that *Trancework* is an excellent exposition of current teachings on Ericksonian therapy or, as the author prefers to say, of the naturalistic approach originated by Milton H. Erickson.

The naturalistic approach to therapy and to hypnotism can be summed up in a few words: It is the use by the therapist of whatever capacities and kinds of responses the patient has and is capable of giving at any particular moment; even his or her symptoms can be used.

Trancework is also an excellent introduction to strategic therapy, which is an outgrowth of this naturalistic approach. Strategic therapy was originally defined quite broadly by Jay Haley (as a result of his study of Erickson's therapeutic work) as any therapy in which the therapist takes the responsibility of directly influencing the patient according to a plan of treatment determined by the presenting problem. But to be a true reflection of Erickson's approach, as it was intended to be, this definition should have added that the plan is also determined by what can be used out of what is offered by the patient at any given moment, a plan that is both fluid and unique for each patient. It is in this sense that I see *Trancework* as an exposition of strategic therapy.

However, *Trancework* is not just an exposition of Ericksonian methods or of strategic therapy. It is more; it is a reflection of Michael Yapko's personal understandings, skills, and experience as a psychotherapist and psychologist. One way of summing up Erickson's approach to psychotherapy is to say that it is an integration of hypnotic and nonhypnotic phenomena brought about naturalistically for therapeutic purposes. It is to Yapko's credit that he has been able not only to capture the essence of this approach but also to make it available in a practical way.

While the author's subject matter is primarily clinical hypnotism as viewed from within a naturalistic framework, he does not ignore matters pertaining to traditional hypnotism and introduces the reader to its principal concepts and methods. With fairness, he points out the strengths and weaknesses of the two approaches as he sees them, although clearly giving his overall preference to the naturalistic approach.

There is considerable didactic material in *Trancework*, but the book remains above all a practical work aiming not only to teach the reader the art of doing hypnotherapy but, more importantly, the art of doing effective psychotherapy. For, as already intimated, it is in the nature of the Ericksonian approach not to separate the use of hypnotic patterns of communication from therapeutic communications in general. For both Erickson and Yapko, effective communication is the key to both the skilled use of hypnotic phenomena and to effective psychotherapy. One may not necessarily agree with the author that all influencing communications constitute hypnosis—which seems to be his position—but there is no question that readers who practice the communication techniques he details will be well on their way to becoming skilled clinical hypnotists and therapists.

A valuable pedagogical feature of the work that should not be overlooked is the lists of topics for discussion and the assignments with which each chapter terminates. Readers would be well advised to give them their attention.

Trancework will be a good starting point for beginners and a good review for more advanced workers. It brings together a great deal of material, and should be particularly instructive for practitioners who have thus far limited themselves strictly to the traditional approach.

André M. Weitzenhoffer, PhD
Nathrop, Colorado

INTRODUCTION TO THE 2ND EDITION

When *Trancework* first came out in 1984, it was riding on a wave of enthusiasm for the creative approaches to hypnosis and hypnotically based psychotherapy of the late Milton H. Erickson, MD. The focus on Erickson and his innovative methods has spawned a whole new generation of clinicians interested in hypnosis and the applications it may have in various clinical contexts. *Trancework* is not a book about Erickson, though. It is a book about practical methods for developing the kinds of relationship and communication skills that will increase the effectiveness of your clinical methods, regardless of the context in which they are applied. I am a practical-minded fellow who is interested in therapeutic patterns that work. Erickson's emphasis was also a practical one, which I can appreciate. His influence on the material contained here is significant.

This second edition represents an effort to make the acquisition of skills to apply hypnosis more easily accomplished by the reader. The exercises and discussions can be the most powerful teachers of hypnotic skill, but this revised edition presents new features that will enhance the learning process. First, two new chapters have been added. Chapter 19 contains transcripts of portions of actual hypnosis sessions conducted with bona fide clients. Chapter 20 presents a verbatim clinical session in its entirety, including commentary intended to amplify points of interest in the learning of hypnotic communication. Both new chapters are intended to provide greater insight into the clinical applications of hypnosis and are considered a valuable addition to the text.

Another new feature is the Frames of Reference sections, which include worthwhile quotes on a variety of stimulating topics from leading figures in the field. These Frames of Reference provide an enjoyable glimpse into the thinking and the history of notable authorities. The reader will note that the Frames of Reference are listed separately, immediately following the table of contents.

Also new to this edition are 20 tables that clearly and succinctly provide key information. These tables can be easily memorized, allowing more rapid integration of the material. What makes hypnosis so potentially useful a tool?

Is it the emphasis on acknowledging and respecting the subjective reality of each individual client? Is it the emphasis on the cooperative nature of the therapeutic relationship? Is it the enhanced appreciation and use of the recognition that words can heal? Certainly, all these are factors contributing to the effectiveness of hypnotic patterns, but the strength of doing trancework comes from undefinable sources within each human being. Whether these are termed the "unconscious," "inner wisdom," "the God within," or some other equally ambiguous name, there is a remarkable potential in each person that surfaces during those states of absorption called "trance" that one can readily appreciate. If there is a more dynamic and potent means of empowering individuals than by working hypnotically, I am not yet aware of it.

It is unfortunate, but nonetheless true, that the field of hypnosis remains an internally conflicted one. The focus on the clinical approaches of Erickson has been substantial in the last decade, and it is a basic truth that every movement creates a countermovement. While many were (noncritically) touting the wonders of "Ericksonian hypnosis," others were openly criticizing the apparent lack of objectivity in such strong claims. Just as there are divisions in the field of psychotherapy, there are those who align themselves with one model of hypnosis and openly express disapproval for any other model. It is my hope that *Trancework* will permit you to sidestep issues of alignment and instead focus on issues associated with discovering how you as an individual practitioner can best apply these approaches in a manner congruent with your training and personality. While I generally favor the flexibility of less direct and imposing techniques, I am quite aware that what works well for me may not work as well for someone else.

Knowing what I know about trance states and ways to induce and use them, I am inclined to integrate the seemingly irreconcilable views about hypnosis. I generally promote the perspective that while the experimental production of specific trance phenomena is not an apparent capability of all people the "real-life" use of specific trance phenomena to create reality (including wellness and illness) is evident in all. The question of what is and what is not "trance" is interesting fodder for debates that cannot be won but is irrelevant when a client is in distress and needs a skilled, flexible, creative therapist to interrupt self-limiting patterns while building self-enhancing ones.

Technique is inevitably bound to context. What succeeds in one context can be faithfully duplicated but still yield unfortunate results in another context. What *Trancework* is ultimately about is synthesizing what is known about social influence, communication, psychotherapy, and clinical hypnosis to sensitize you to the healing power of words, the healing power of beliefs, and the healing power of relationships.

In that regard, I have chosen not to focus on facts and issues unrelated to the development of actual skills in using hypnosis. Detailing the ancient history of hypnosis or reporting unusual experiments with hypnosis that lead

to nonclinical questions such as whether or not hypnosis can be used to get someone to rob a bank is simply not consistent with my aim in writing *Trancework*. I am all too aware that most professionals do not get their hypnosis training in academic institutions—they get it in privately sponsored workshops. If you are taking a university-sponsored course in hypnosis, consider yourself fortunate to have some progressive aspects in your curriculum. Most hypnosis training takes place in small groups of interested and experienced clinicians. As one who routinely offers such training, I am aware of the participants' desire to focus on skill-building above all else. For this reason, I have included things to discuss and things to do in every chapter. The conceptual framework of the first part of the book is simply a foundation for more easily assimilating the techniques of the second part of the book. The true skills, however, come only with practice, as you would naturally expect.

I would like to make one final point about usage in this edition. Rather than refer to people exclusively as male, as tradition suggests, or exclusively as female, as I did in the first edition, I have consistently made use of both male and female pronouns in an inconsistent way, throughout the book—male and female therapists, male and female clients—just like in the real world.

I hope you find *Trancework* a valued ally in your efforts to learn clinical hypnosis. More importantly, I hope you find resources in yourself you can appreciate as you learn.

Michael D. Yapko, PhD
San Diego, California

FOREWORD TO THE 1ST EDITION

Milton Erickson was known for his flexible and effective therapeutic communication, which was predicated to a great extent on his ability to read nonverbal behavior. Early in my training with Erickson, I asked for instruction to be able to better understand nonverbal behavior. In an amused fashion, he asked if I knew the definition of "zyzzyx." I replied that I did not and asked what it meant. He instructed me to look it up in the dictionary, stating that you first learn the alphabet, then the words, then the grammar. There is no substitute for direct experience, and, before one goes on to complex tasks, it is important to really know the basics.

In this volume, Michael Yapko presents the alphabet of hypnotic influence communication based in part on Erickson's strategic and symptom-based therapy, a methodology that uses hypnosis both formally and naturalistically to promote change. Whereas traditional therapy made understanding and insight primary, Ericksonian methods center on promoting effective living independent of the therapeutic situation. To accomplish goals and to maximize patient-based change, Erickson pioneered indirect techniques, noting

that communication occurs on multiple levels, including the verbal content, the implications, and such extraverbal factors as tone, duration, intensity, and body language. In fact, some experts maintain that only a small fraction of our response to communication is due to the verbal content.

Traditional therapists interpret the patient's multiple level communication, that is, describe back to the patient what he "really means." Modern Ericksonian methods, however, are predicated on the idea that if the patient is intelligent enough to communicate on more than one level, the therapist should be equally intelligent. Therapeutic communication does not need to be interpretive, concrete, direct, or linear to be effective. In fact, therapeutic communication is best when the therapist is flexible, uses indirect techniques, and focuses as many output channels of communication as possible (Zeig, 1980).

Yapko gently eases us into the world of hypnotic communication. He provides a balance between direct and indirect techniques, integrating clear examples of each approach into the text. Examples also are given of content and process techniques (roughly, those that are specific and those that are more general). Direct and indirect techniques along with process and content suggestions have their place in therapy. Yapko does not tell us which to use or when to use them; rather, he examines possibilities, presenting the advantages and disadvantages of each, reminding us that the amount of indirection to be used is directly proportional to the perceived resistance.

Yapko's approach to hypnosis is a radical departure from other authorities. He defines hypnosis as influence communication—a position sure to be considered controversial because some might think that definition too general, thereby unnecessarily diluting the territory. However, Yapko presents his arguments cogently and has a position that deserves recognition in the literature and can be supported by citations and references.

Trancework was written to promote clinical hypnosis and to make it more available to psychotherapists. It will motivate many to enter the field and broaden their interests so that there will be active use of and research into hypnotic communication.

I find this book particularly interesting when it describes the induction process, the use of trance phenomena, and the wording of different types of suggestions. Professionals will appreciate the attention given to the ethical use of hypnosis. In good Ericksonian fashion, we are admonished to attend to individual differences and meet the patient at his frame of reference; the emphasis is on communication skills, not on rigid formulas.

Trancework provides the building blocks necessary to learn the vocabulary and grammar of hypnotherapy and effective forms of influence communication. We look forward to other expositions from this talented writer.

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INTRODUCTION TO THE 1ST EDITION

If the word "hypnosis" conjures up images of a powerful, magician-like figure dangling a gold watch in the face of a stuporous subject while giving the command to "sleep deeply," then you are in a for a pleasant surprise. Not only is that not what clinical hypnosis is all about, but that old stereotype of hypnosis has little relevance to the current perspective of hypnosis as a rich system of communication.

Hypnotic patterns are evident wherever influential communication occurs. The artistry of meaningful applications of hypnosis can be appreciated when one considers the dynamics of how one person can use communication to alter the experience of another.

It is my hope and anticipation that hypnosis will become a significant part of your range of interactional skills, even if after reading this book you never formally induce a trance in anyone for the remainder of your life. Although that may seem a grandiose goal for a hypnosis book, many years of teaching hypnosis to practicing professionals and graduate students have convinced me that the skills in communication described in this book can make a positive difference in the work you do and in the relationships you form with virtually everyone.

So much has happened in recent years in the fields of clinical hypnosis, clinical psychology, communications, linguistics, neurology, and other fields relevant to understanding human behavior that the impact has yet to be fully appreciated. Certainly a revolution has taken place in perspectives on hypnosis, described throughout this book. In the past there have been numerous theories explaining the various phenomena associated with the trance state, yet the practice of hypnosis was generally limited to one of two forms: (1) the "traditional" application of hypnosis emphasizing the power of the hypnotist in relationship to an obedient subject (this approach is best represented by the stage hypnotist); and (2) a "standardized" approach emphasizing the responsibility of the client to adapt herself to a scripted, and therefore nonindividualized, program of the hypnotist (best represented by prepackaged tapes and "cookbook" treatments). Both approaches have been quite limited in their ability to obtain positive results reliably (see Appendix A).

Fortunately, the field of hypnosis has evolved past these two limited approaches in recent years. This development is due in large part to the innovative and untiring work of the late psychiatrist and hypnosis pioneer Milton H. Erickson, MD. Erickson evolved his own unique techniques that could recognize and use the creativity and individuality of each person. Recently,

numerous texts and articles have flooded the hypnosis literature promoting Erickson's methods, collectively called the "utilization" approach, though also referred to as "Ericksonian hypnosis." In this model, emphasis is placed upon the use of as many dimensions of the client's inner world as possible, particularly the unconscious mind's unique resources.

The progression of hypnosis as a field beyond demanding blind obedience and offering scripted routines has radically changed its conceptual and practical frameworks. Hypnosis is no longer the "occultish" mystery it once was, although undeniably there are still things about hypnosis remaining to be explained. With the progression in understandings about hypnosis has also come acceptance. Although most people encountering hypnosis for the first time still do so in a stage show context, increasing numbers of people are also being made aware of its clinical and other appropriate professional uses. Typically, they have been made aware through the media, which frequently runs programs and articles on hypnosis or through friends who have obtained help through hypnosis.

The sole purpose of this book is to introduce professionals to the rich and complex world of clinical hypnosis. I hope it will allow you to acquire a comprehensive understanding of the concepts and issues related to its practice and to acquire the basic skills that only years of regular practice and continued pursuit of excellence can build upon. Reread, if you don't mind, the last sentence. It is one written with great sincerity. To become truly skilled in the use of hypnosis (or any other worthwhile endeavor for that matter) takes a great deal of time and commitment. This book can provide a broad and solid framework of understanding and experience that more advanced, specialized studies of hypnosis can build upon.

There are plenty of books, cassette and videotape packages, and training programs that promise to make you a hypnotist "overnight." They are not lying, either, for you can be a hypnotist overnight. Guiding a person into trance is not particularly difficult, nor is reading a prepared script to the hypnotized subject. Such approaches may even get some positive results occasionally. However, obtaining consistent results across a wider range of client concerns requires a sensitivity and deeper knowledge that is not available in such approaches. Developing sensitivity to the individual needs of the client and learning how to best develop her unique inner resources is not taught in the "overnight hypnotist" programs. Only rigid formulas are. The oversimplifications of the traditional and standardized approaches make them, in many instances, undesirable for use.

Unfortunately, a powerful tool like hypnosis can be placed in the hands of people who are not in a position to appreciate the full implications of its use. This is another reason anyone can be a hypnotist: It is legal for anyone who wants to to hang out the "hypnotist" shingle on her door with no formal credentials, not even a high school diploma. Hypnotists who are untrained in the health professions are routinely providing physical and psychological health care, under ambiguous names of course, but health care nonetheless.

Some are really quite good at what they do, but the potential dangers should be apparent.

After you have read this book you will be faced with decisions about how much more, if any, training and proficiency you want to obtain. Beyond what you will be aware of learning, you can learn a great deal more without even realizing you are learning, and perhaps you can decide to learn just enough to take pride in your knowledge and skills. This is a book for training in hypnosis. There are exercises to do, concepts and terms to master, and points to discuss. I encourage you to experience and practice all the techniques you can. Ultimately, you can read about hypnosis, then read more about it, and talk about it, and then read still more about it, but there is no substitute for hours and hours of working with it. A lot of commitment, but the payoff is most rewarding.

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AUTHOR INDEX

A

Aarts, H., 92, 566
Abraham, H., 434, 559
Abramowitz, E., 248, 580
Adams, D., 78, 595
Afzal, A., 137, 572
Aikins, D., 75, 588
Aker, J., 136, 571
Akert, R., 141, 144, 149, 560
Alborzian, S., 86, 563
Alladin, A., 8, 12, 31, 187, 378, 559, 570
Allen, S., 187, 566
Alpert, N., 82, 395, 578
Amundson, J., 8, 559
Anbar, R., 493, 499, 559, 580
Andreas, S., 432, 559
Araoz, D., 174, 412, 435, 559
Argast, T., 24, 377, 559
Arnold, M., 344, 560
Aronson, E., 22, 141, 144, 145, 149, 158, 560, 595
Asch, S., 150, 560
Askay, S., 499, 560
Atkinson, G., 51, 166, 168, 595
Atwater, F., 78, 560
Aviv, A., 493, 560
Azzarelo, G., 499, 582

B

Baker, E., 12, 174, 175, 418, 560, 584
Bakke, A., 138, 560
Bandler, R., 294, 328, 560, 572
Banerjee, S., 493, 560
Bányai, É., 41, 344, 560
Barabasz, A., 5, 8, 12, 38, 40, 57, 66, 68, 78, 81, 109, 136, 137, 218, 219, 222, 223, 248, 251, 257, 303, 306, 310, 314, 371, 433, 480, 487, 488, 493, 504, 511, 546, 547, 560, 561, 572, 575, 581, 591
Barabasz, M., 40, 66, 68, 78, 81, 137, 223, 257, 560, 561, 575
Barasch, E., 578
Barbato, F., 499, 582
Barber, J., 19, 30, 38, 51, 109, 161, 218, 233, 241, 266, 367, 400, 499, 505, 561
Barber, T., 17, 41, 54, 101, 118, 154, 157, 161, 166, 167, 168, 169, 184, 186, 187, 344, 359, 361, 369, 436, 516, 547, 561, 598
Bargh, J., 48, 92, 93, 561, 598
Barker, D., 493, 566
Barker, P., 334, 562
Barlow, D., 428, 562
Barnier, A., 165, 166, 174, 178, 182, 183, 238, 320, 359, 562, 583
Barrett, D., 5, 25, 36, 167, 493, 562, 572
Barretta, N., 107, 562
Barretta, P., 107, 562
Bates, B., 251, 562
Battino, R., 334, 562
Beaulieu-Prévost, D., 165–166, 168, 579
Beck, A., 83, 187, 562
Beecher, H., 123, 562
Beekman, A., 132, 587
Beiser, A., 133, 591
Bejenke, C., 382, 500, 562
Belicki, D., 174, 562

Belicki, K., 174, 562
Bell-Gadsby, C., 434, 562
Belli, R., 224, 562
Bellusci, A., 248, 567
Belmont, K., 478, 572
Benham, G., 106, 562
Benninga, M., 493–494, 596
Benotsch, E., 136, 499, 579
Benson, D., 83, 566
Benson, H., 126, 562
Benson, S., 257, 303, 571
Berbaum, K., 136, 499, 579
Berbaum, M., 136, 499, 579
Berberich, F., 486, 563
Bergman, M., 249, 563
Bernheim, H., 50, 563
Bhardwaj, A., 493, 580
Bhasin, M., 126, 568
Bjick, E., 75, 588
Blai, A., 75, 588
Blanchard, E., 500, 571
Blank, A., 160, 579
Bliss, E., 174, 563
Bloom, J., 382, 594
Bloom, P., 227, 563
Bloy, A., 493, 598
Blume, S., 347, 563
Boas, D., 85, 567
Bordens, K., 27, 38, 563
Borek, L., 133, 563
Botts, P., 493, 577
Bovbjerg, D., 500, 583
Bower, G., 574
Bowers, K., 49, 81, 563, 595
Bowman, E., 529, 563
Bowman, M., 493, 579
Brady, B., 78, 563, 595
Brady, S., 133, 591
Braffman, W., 83, 577
Brentar, J., 38, 218, 233, 570
Brody, A., 86, 563
Brooks, P., 136, 571
Brown, D., 12, 175, 347, 500, 563
Brown, J., 518, 563
Brown, P., 58, 334, 425, 563
Brown, R., 166, 563
Brummett, B., 133, 564
Bryant, R., 166, 359, 565
Buhle, J., 49, 589
Burger, J., 147, 564
Burgess, C., 83, 577
Burnett, C., 12, 586
Burns, G., 199, 207, 334, 424, 489, 564
Burrows, G., 218, 575
Bushnell, M., 82, 588
Butler, L., 237, 478, 493, 499, 564, 572, 576
Byrne, R., 102, 564

C

Cadegan, K., 433, 564
Calof, D., 143, 564
Calvin, S., 68, 81, 257, 561
Campbell, W., 214, 596
Capafons, A., 36, 41, 421, 499, 564, 582
Carbis, C., 69, 75, 597
Cardeña, E., 8, 12, 136, 184, 192, 499, 546, 547, 564, 581, 582
Carlson, J., 468, 589
Carney, R., 132, 564
Carr, R., 110, 576
Carrell, P., 24, 377, 559
Carrier, B., 82, 588
Castel, A., 499, 582
Catchpole, R., 481, 579
Catell, A., 499, 564
Chanowitz, B., 160, 579
Charney, D., 132, 572
Chaves, J., 53, 60, 109, 154, 344, 561, 564, 593
Cheek, D., 368, 379, 564, 590
Cheung, A., 499, 568
Cheung, L., 522, 573
Christensen, C., 56, 137, 561, 564
Church, D., 125, 126, 570
Ciorciari, J., 69, 75, 597
Clarke, J., 110, 564
Clarke, S., 76, 566
Classen, C., 394, 594
Coe, W., 54, 218, 306, 314, 565, 591, 593
Cohen, S., 238, 565
Coleman, S., 100, 232, 568
Colletti, G., 174, 369, 565
Colligan, R., 133, 582
Collison, D., 493, 565
Colwell, S., 493, 577
Consoli, A., 517, 565
Constantini-Ferrando, M., 82, 395, 578
Constantino, C., 478, 583
Cook, I., 354, 575
Coons, P., 529, 563
Cooper, L., 173, 382, 511, 565
Corballis, M., 76, 565
Corby, J., 78, 566

Costa, P., 166, 565
Costa, S., 116, 575
Council, J., 165, 166, 168, 174, 238, 320, 359, 562, 565, 577, 584
Covino, N., 131, 136, 310, 565, 588
Cox, R., 166, 359, 565
Coyle, J., 75, 588
Crabtree, A., 498, 565
Craighero, L., 72, 589
Crawford, H., 66, 68, 69, 75, 76, 78, 80, 81, 83, 86, 187, 505, 566, 575, 591
Cross, D., 183, 192, 593
Crowley, R., 489, 583
Csikszentmihalyi, M., 18, 204, 592
Cummings, J., 232, 233, 420, 566
Cummings, N., 232, 233, 420, 566
Custers, R., 92, 566
Cutcomb, S., 75, 591
Cyna, A., 493, 566

D

Dahl, J., 503, 567
Dahlstrom, W., 133, 564
Daitch, C.., 428, 567
Damaser, E., 229, 567
David, D., 319, 399, 500, 583, 596
Deeg, D., 132, 587
Delaney, M., 22, 219, 343, 361, 596
Denner, J., 85, 567
Dennerstein, L., 218, 575
De Pascalis, V., 69, 76, 78, 248, 567
Detweiler-Bedell, J., 420, 567
De Vos, H., 116, 567
Diamond, M., 177, 241, 567
Diamond, S., 85, 567
Dictionary.com, 122, 567
Dinges, D., 228, 229, 567, 585
Doidge, N., 73, 85, 567
Donatone, B., 493, 568
Donchin, E., 78, 568
Dondershine, H., 174, 594
Downs, J., 68, 575
Dube, S., 133, 596
Du Chéné, T., 165–166, 168, 579
DuHamel, K., 499, 583
Duncan, B., 15, 21, 100, 232, 568, 575
Duncan, G., 82, 588
Duncan-Johnson, C., 78, 568
Dupuis, L., 499, 568
Dusek, J., 126, 568

E

Eccleston, C., 503, 583
Edgette, J., 313, 374, 382, 568
Edgette, J., 313, 374, 382, 568
Edmonds, P., 499, 588
Egner, T., 71, 568
Ehde, D., 136, 586
Eichel, S., 219, 568
Eimer, B., 378, 379, 415, 505, 568, 570, 599
Eisen, M., 94, 371, 568
Eli, I., 38, 218, 577
Elkins, G., 106, 122, 499, 568
Elliott-Carter, N., 183, 194, 587
Emery, G., 83, 187, 562
Engel, G., 131, 568
Epley, N., 93, 568
Erdelyi, M., 116, 568
Erickson, B., 97, 424, 568
Erickson, E., 382, 569
Erickson, M., 52, 96, 98, 130, 145, 209, 273, 296, 312, 320, 336, 356, 366, 382, 397, 418, 470, 471, 475, 479, 480, 481, 506, 507, 509, 510, 511, 529, 565, 568, 569
Erickson-Klein, R., 128, 590
Erikson, E., 205, 569
Esdaile, J., 497, 569, 578
Eskes, G., 83, 595
Espejo, B., 499, 582
Espie, C., 499, 598
Ewin, D., 136, 379, 499, 570

F

Fairbanks, L., 86, 563
Fan, J., 68, 71, 589
Fava, M., 434, 559
Feinstein, D., 125, 126, 570
Feldman, J., 502, 503, 512, 570
Fergusson, D., 133, 570
Festinger, L., 158, 431, 570
Fezler, W., 111, 578
Fick, L., 136, 499, 579
Field, P., 182, 570
Finkelstein, S., 110, 570
Fisch, R., 422, 423, 597
Flammer, E., 12, 570
Flory, N., 499, 570
Flynn, D., 151, 593
Forrest, M.S., 592
Foster, J., 83, 595
Frackowiak, R., 68, 597

Fraioli, S., 40, 581
Frankel, F., 174, 570
Frauman, D., 38, 194, 218, 233, 570, 581
Frederick, C., 371, 420, 588
Fredrickson, R., 143, 347, 570
Freed, S., 497, 578
Freedland, K., 132, 564
Fricton, J., 266, 570
Friedlander, E., 124, 138, 576
Friedman, J., 133, 563
Frischholz, E., 231, 238, 249, 570
Fukui, T., 500, 595

G

Gabora, M., 151, 593
Gafner, G., 257, 303, 570, 571
Galovski, T., 500, 571
Gatchel, R., 502, 571
Gazzaniga, M., 49, 76, 571
Geary, B., 166, 250, 404, 510, 571, 600
Gendlin, E., 18, 571
Gfeller, J., 22, 31, 166, 177, 187, 246, 571
Giannelli, P., 231, 571
Gibbons, D., 22, 302, 303, 314, 324, 400, 465, 571
Gifford, E., 266, 574
Gilbert, J., 78, 595
Gillies, L., 86, 563
Gilligan, S., 31, 174, 241, 264, 328, 336, 366, 471, 509, 530, 531, 532, 571
Ginandes, C., 106, 136, 571
Glaser, R., 136, 571
Gold, J., 478, 572
Gold, P., 132, 572
Goldberg, M., 136, 586
Goldman, R., 493, 589
Goleman, D., 477, 572
Gollub, R., 68, 578
Gonsalkorale, W., 137, 500, 572
Goodwin, R., 133, 570
Gorassini, D., 22, 31, 32, 166, 177, 187, 246, 571, 572
Gordon, B., 74, 572
Gottdiener, J., 578
Gottheil, E., 382, 594
Gottman, J., 430, 572
Graci, G., 12, 572
Graffin, N., 75, 572
Gravitz, M., 40, 498, 529, 572
Gray, J., 93, 580, 598
Green, J., 5, 12, 41, 53, 54, 92, 172, 415, 479, 505, 516, 572, 581, 586
Greenleaf, F., 464, 572
Greve, D., 580
Grinder, J., 294, 328, 560, 572
Groth- Marnat, G., 266, 573
Gruzelier, J., 69, 71, 75, 76, 83, 137, 566, 568, 573, 576, 598
Guindi, D., 76, 589
Gur, R.C., 83, 566
Gur, R.E., 83, 566
Guyer, C., 493, 573

H

Haga, Z., 78, 595
Haley, J., 21, 29, 52, 96, 100, 264, 291, 330, 332, 338, 360, 420, 421, 422, 424, 431, 436, 467, 468, 470, 472, 487, 573
Halfmann, R., 125, 573
Halligan, P., 49, 65, 66, 67, 68, 69, 94, 184, 585, 597
Hallquist, M., 53, 124, 152, 581
Halsband, U., 85, 573
Ham, J., 72, 582
Hamalainen, H., 83, 576
Hamilton, D., 136, 579
Hammond, D., 12, 43, 110, 231, 334, 347, 348, 498, 499, 500, 563, 573, 597
Hanh, T.N., 522, 573
Hannoun, S., 500, 585
Hanson, R., 520, 573
Hardie, J., 12, 572
Harrington, G., 68, 575
Harrison, D., 76, 566
Hart, J., 75, 581
Hartman, W., 371, 573
Hassett, L., 499, 574
Hatira, P., 493, 580
Hawley, P., 116, 575
Hayes, S., 266, 503, 567, 574
Heap, M., 27, 43, 218, 348, 359, 574, 582
Heimel, A., 493, 577
Heller, W., 76, 574
Helms, M., 133, 564
Henderson, S., 493, 499, 564
Hermesh, H., 493, 599
Hexum, A., 264, 585
Hidderley, M., 138, 574
Higginson, I., 499, 588
Higley, L., 137, 561
Hilgard, E., 9, 31, 41, 48, 49, 57, 69, 90, 94, 165, 166, 169, 173, 175, 182, 184, 185, 218, 240, 243, 244, 245, 247, 248, 368, 379, 478, 479, 560, 574, 584, 588, 597

Hilgard, J., 167, 478, 574, 584
Hinterberger, T., 85, 573
Hoffman, H., 346, 499, 580, 586
Holroyd, J., 76, 77, 109, 187, 574
Holt, M., 138, 574
Honig, A., 132, 587
Horne, R., 174, 587
Hornyak, L., 172, 574
Horowitz, I., 27, 38, 563
Horton, J., 68, 80, 575
Horwood, L., 133, 570
Houghton, L., 500, 572
Howard, N., 494, 585
Howe, R., 85, 567
Hubble, M., 15, 21, 575
Hudacek, K., 137, 138, 575
Huff, K., 168, 565
Hull, C., 41, 238, 244, 575
Hummell, K., 493, 559
Hunt, T., 174, 594
Hunter, A., 354, 575

I

Iglesias, A., 493, 575
Isenberg, G., 529, 575

J

Jacobson, E., 306, 575
Jacobson, N., 116, 575
Jamieson, G., 69, 71, 84, 568, 575
Jamison, S., 86, 505, 566
Jensen, M., 12, 106, 107, 496, 499, 500, 503, 510, 511, 512, 560, 568, 575, 585, 586, 595
Jensen, S., 68, 81, 257, 561, 575
Jester, C., 517, 565
Johnson, D., 12, 586
Johnson, G., 359, 575
Jones, C., 136, 571
Jones, G., 122, 586
Joseph, M., 126, 568
Joyce, J., 136, 579
Judd, F., 218, 575

K

Kabat-Zinn, J., 520, 522, 524, 575, 576
Kachelski, R.A., 93, 568
Kafer, I., 136, 591
Kahn, S., 374, 375, 382, 430, 576
Kaiser, P., 488, 491, 492, 493, 576
Kalish, Y., 248, 580
Kallio, S., 83, 249, 563, 576
Kandel, E., 346, 365, 576, 594
Kane, M., 49, 589
Kane, S., 171, 576
Kant, A., 478, 572
Kapelis, L., 76, 566
Kaplan, L., 86, 505, 566
Kaptchuk, T., 68, 124, 138, 576, 578
Kase, C., 133, 591
Katon, W., 132, 576
Keefe, G., 496, 576
Keeney, B., 97, 568
Keller, S., 493, 589
Kelley, J., 124, 138, 576
Kelly, M., 110, 576
Kelly-Hayes, M., 133, 591
Kennedy, W., 123, 576
Kerr, C., 580
Kershaw, C., 430, 576
Keuroghlian, A., 237, 576
Kiecolt-Glaser, J., 136, 571
Kihlstrom, J., 8, 14, 36, 49, 51, 54, 70, 90, 91, 166, 184, 187, 319, 359, 576, 595
Kim, Y., 249, 588
Kingsbury, S., 493, 576
Kirsch, I., 8, 9, 12, 14, 15, 17, 21, 22, 31, 38, 41, 42, 53, 68, 70, 83, 94, 101, 124, 136, 146, 151, 152, 157, 158, 166, 168, 169, 177, 184, 218, 221, 224, 238, 251, 253, 306, 319, 349, 354, 355, 378, 399, 415, 499, 505, 522, 546, 547, 576, 577, 578, 581, 589, 596
Kitner-Triolo, M., 76, 566
Klein, M., 435, 577
Klein, S.K., 493, 580
Kleinhauz, M., 38, 218, 577
Knebel, T., 86, 505, 566
Kohen, D., 173, 479, 480, 481, 483, 487, 492, 493, 499, 529, 577, 578
Kohn, R., 133, 563
Kokkotou, E., 124, 138, 576
Kong, J., 68, 578
Kop, W., 578
Kopell, B., 78, 566
Kosslyn, S., 82, 395, 578
Kraemer, H., 382, 594
Kramer, S., 116, 575
Kristjánsson, K., 209, 578
Kroenke, K., 132, 578
Kroger, W., 106, 110, 111, 118, 152, 382, 479, 493, 497, 498, 500, 578
Kronenberger, W., 240, 578
Kubie, L., 418, 569

Kuhl, E., 578
Kumar, V., 183, 194, 433, 564, 587
Kunz-Ebrecht, S., 133, 594
Kuttner, L., 481, 493, 578, 579

L

LaClave, L., 240, 493, 578, 591
Lagges, A., 493, 591
Lamar, M., 49, 589
Lambert, M., 518, 579
Landis, R., 24, 377, 559
Lang, E., 136, 499, 570, 579
Langer, E., 160, 579
Lankton, C., 19, 264, 324, 334, 420, 579
Lankton, S., 5, 18, 19, 264, 320, 324, 334, 361, 371, 419, 420, 424, 572, 579
Laskowski, B., 136, 571
Laurence, J.-R., 165–166, 168, 174, 238, 369, 565, 579
Lawlor, E., 493, 579
Lazar, S., 580
Lazarus, J., 493, 580
Lazarus, R., 208–209, 580
Le Bars, D., 500, 585
LeCron, L., 182, 379, 564, 580
Lee, K., 136, 579
Leibovitz, M., 75, 581
Lemke, W., 435, 580
Leuchter, A., 354, 575
Levitan, A., 499, 580
Levitt, E., 434, 580
Lichtenberg, P., 248, 580
Liggett, D., 117, 580
Liley, C., 69, 75, 597
Linden, J., 172, 493, 580
Lindquist, S., 125, 573
Linssen, A., 499, 594
Liossi, C., 493, 499, 580
Lippman, L., 477, 583
Lliffe, S., 133, 594
Loftus, E., 224, 346, 347, 562, 580, 581
London, P., 75, 173, 478, 565, 581
Lonsdale, C., 78, 561
Loriedo, C., 430, 581
Louw, W., 116, 567
Lubar, J., 78, 581
Luciano, C., 503, 567
Lundy, R., 75, 572
Lutgendorf, S., 136, 499, 579
Lynch, D., 499, 581
Lynn, S., 8, 9, 12, 15, 17, 22, 31, 32, 38, 40, 41, 42, 53, 54, 58, 92, 101, 124, 136, 145, 146, 148, 151, 152, 158, 160, 166, 172, 174, 178, 184, 194, 218, 221, 224, 231, 233, 238, 239, 251, 253, 263, 266, 302, 303, 306, 310, 314, 319, 324, 349, 369, 378, 399, 400, 415, 420, 465, 493, 499, 505, 516, 546, 547, 565, 570, 571, 572, 577, 581, 582, 589, 596
Lyubomirsky, S., 211, 582

M

MacCallum, R., 136, 571
Mackey, E., 109, 499, 582
Maddock, T., 493, 566
Malarkey, W., 136, 571
Malinchoc, M., 133, 582
Mann-Rinehart, P., 529, 578
Marchioro, G., 499, 582
Marci, C., 72, 582
Marcus, C., 136, 591
Marcus, H., 493, 582
Marcus, J., 122, 499, 568
Mare, C., 263, 266, 582
Markela, J., 83, 576
Marquis, E., 574
Martin, D., 194, 581
Martin, E., 86, 582
Martin, S., 86, 582
Martinez-Valero, C., 499, 582
Marucci, F., 76, 567
Marucha, P., 136, 571
Maruta, T., 133, 582
Maslow, A., 205, 582
Mason, A., 153, 582
Matthews, A., 40, 581
Matthews, W., 152, 264, 320, 529, 575, 579, 582
Matyi, C., 263, 266, 582
Maurer, R., 183, 194, 587
Mayer, R., 518, 582
Mazzoni, G., 43, 348, 359, 582
McCall, G., 499, 589
McConkey, K., 14, 57, 58, 83, 110, 114, 166, 178, 181, 182, 183, 188, 192, 221, 238, 249, 562, 583, 589, 592, 593
McCracken, L., 503, 583
McCrae, R., 166, 565
McKinty, H., 110, 576
McNeilly, R., 403, 583
Meier, B., 166, 584
Mellinger, D., 12, 40, 581, 583

Mendius, R., 520, 573
Mendoza, E., 36, 41, 421, 564
Menko-Frankenhuis, C., 493–494, 596
Milano, M., 58, 582
Milgram, S., 146, 147, 148, 150, 583
Miller, S., 15, 21, 100, 232, 568, 575
Miller, V., 122, 137, 572, 583
Milling, L., 478, 583
Mills, J., 488, 489, 583
Mitchell, K., 266, 573
Montgomery, G., 5, 12, 136, 172, 499, 500, 572, 577, 583, 586, 591
Moon, E., 183, 194, 587
Moore, K., 477, 583
Moore, M., 8, 12, 187, 583
Moran, E., 72, 582
Morgan, A., 166, 173, 478, 479, 584
Morgan, M., 354, 575
Morgan, W., 117, 584, 594
Morrow, C., 240, 578
Mueller, S., 85, 573
Mullen, K., 194, 587
Mulligan, R., 109, 499, 584
Munion, W., 281, 600
Murray, K., 493, 578
Murray-Jobsis, J., 175, 584
Myers, D., 141, 144, 149, 208, 209, 584

N

Nadon, R., 238, 584
Nahmias, C., 81, 595
Nash, M., 9, 12, 22, 36, 51, 174, 184, 224, 302, 306, 310, 324, 360, 418, 560, 581, 584
Nathan, P., 499, 568
National Institute of Mental Health (NIMH), 584
National Institutes of Health (NIH), 133, 584
Nemeroff, C., 132, 584
Neri, E., 237, 576
Néron, S., 12, 106, 499, 584
Neufeld, V., 263, 266, 582
Newton, P., 138, 560
Nguyen, A.-H., 133, 591
Nichols, L., 249, 570
Nocera, C., 93, 598
Nomura, Y., 491, 597
Nordenstrom, B., 166, 584
Norman, K., 493, 589
Nowlis, D., 75, 585
Nusbaum, F., 500, 585

O

Oakley, D., 49, 65, 66, 67, 68, 69, 94, 166, 184, 563, 585, 597
O'Connor, C., 132, 584
Offord, K., 133, 582
O'Hanlon, W., 264, 334, 585
Olness, K., 171, 173, 479, 480, 481, 483, 487, 492, 493, 576, 577, 578
Olson, D., 494, 585
Oneal, B., 512, 585
Orne, E., 228, 229, 248, 567, 585, 593
Orne, M., 55, 57, 174, 186, 218, 219, 226, 227, 228, 229, 567, 570, 585, 586
Orr, S., 72, 582
Otani, A., 336, 586
Otu, H., 126, 568

P

Padrol, A., 499, 564
Page, R., 479, 586
Palamara, L., 122, 499, 568
Palan, B., 493, 560
Palsson, O., 12, 137, 586
Park, A., 496, 512, 586
Park, N., 204, 206, 207, 210, 211, 586, 592
Parkin, A., 359, 586
Parsons-Fein, J., 70, 71, 431, 586
Patterson, D., 8, 12, 106, 107, 136, 382, 496, 499, 503, 505, 510, 511, 512, 546, 547, 560, 568, 581, 585, 586, 587
Pavanetto, M., 499, 582
Pawlow, L., 122, 586
Peebles, M., 360, 586
Pekala, R., 183, 194, 240, 586, 587
Penna, M., 76, 567
Penna, P., 76, 567
Penninx, B., 132, 587
Perez, M., 499, 564
Pérez, N., 166, 595
Perlini, A., 75, 587
Perry, C., 32, 188, 218, 587, 592
Pessa, E., 76, 567
Peterson, B., 49, 589
Peterson, C., 204, 206, 207, 210, 211, 586, 587, 592
Peterson, S., 69, 588
Pettinati, H., 174, 587
Phillips, M., xvii, xix, 371, 417, 418, 420, 587, 588

Phillips, W., 208, 588
Piccione, C., 166, 588
Pilkington, K., 499, 589
Pilowsky, D., 491, 597
Pinnell, C., 131, 136, 310, 565, 588
Pintar, J., 8, 25, 36, 50, 588
Polich, G., 68, 578
Polster, E., 18, 588
Polster, M., 18, 588
Positive Psychology Center, 204, 588
Posner, M., 68, 69, 71, 588, 589
Pribram, K., 75, 591
Price, D., 82, 588
Purtzer, M., 138, 560
Pyun, Y., 249, 588

Q

Queen, B., 78, 595

R

Radtke, H., 168, 588
Rai, S., 86, 582
Rainville, P., 82, 588
Rajab, H., 499, 568
Rajasekaran, M., 499, 588
Ray, W., 66, 75, 572, 588
Raz, A., 49, 66, 68, 69, 71, 76, 85, 168, 238, 493, 589
Redd, W., 499, 583
Redouté, J., 500, 585
Rennick, P., 17, 100, 473, 600
Revonsuo, A., 83, 576
Reynolds, P., 110, 564
Rhead, J., 75, 585
Rhue, J., 9, 22, 38, 40, 173, 184, 218, 221, 224, 306, 310, 478, 479, 487, 493, 577, 581, 589
Richardson, A., 499, 589
Richardson, J., 499, 589
Richardson, M., 86, 582
Richeport-Haley, M., 468, 589
Rizzolatti, G., 72, 589
Robles, T., 431, 589
Roche, S., 83, 166, 589
Rogers, C., 143, 149, 205, 589
Rogovik, A., 493, 589
Rosen, G., 498, 589
Rosen, S., 264, 331, 424, 590
Rosenfeld, S., 498, 543, 590
Rosetti, F., 499, 582
Ross, K., 128, 590
Rossi, E., 38, 49, 52, 73, 74, 96, 98, 99, 106, 126, 127, 128, 129, 131, 175, 229, 242, 264, 273, 296, 312, 320, 360, 366, 368, 397, 470, 471, 517, 569, 590, 599
Rossi, K., 74, 264, 590
Rossi, S., 273, 296, 312, 320, 470, 569
Roth, P., 266, 570
Royall, R., 86, 582
Ruehle, B., 83, 590
Rull, M., 499, 564
Rush, A., 83, 187, 562
Russo, P., 248, 567
Ryken, K., 218, 565

S

Sabatini, L., 8, 559
Sabourin, M., 75, 591
Sala, J., 499, 564, 582
Salaycik, K., 133, 591
Salazar, G., 499, 570
Sanchez, M., 124, 138, 576
Sánchez-Armáss, O., 248, 591
Sando, W., 136, 571
Sanford, R., 143, 591
Sapirstein, G., 12, 577
Sarbin, T., 42, 54, 55, 185, 313, 314, 375, 565, 591
Savitsky, K., 93, 568
Saxena, S., 86, 563
Schachter, D., 75, 159, 591
Schacter, D., 224, 348, 365, 591
Scheflin, A., 110, 231, 232, 233, 241, 290, 347, 563, 573, 591
Schmidt, A., 512, 586
Schmitz, D., 529, 578
Schnur, J., 136, 591
Schoenberger, N., 12, 591
Schoevers, R., 132, 587
Schwartzman, D., 76, 589
Scoboria, A., 43, 348, 359, 582
Scott, E., 493, 591
Seligman, M., 18, 204, 205, 206, 210, 211, 354, 464, 477, 587, 591, 592
Seltzer, L., 334, 592
Senechal, D., 493, 589
Sever, J., 493, 599
Shapira, H., 248, 580
Shapiro, F., 530, 531, 532, 592
Shapiro, J., 110, 591
Shapiro, T., 85, 589
Sharar, S., 499, 512, 560, 586
Shaw, B., 83, 187, 562

Shaw, R., 494, 585
Sheehan, P., 32, 44, 55, 57, 58, 69, 110, 114, 167, 181, 183, 187, 188, 190, 191, 192, 221, 249, 346, 575, 583, 587, 592, 593
Sheer, D., 76, 593
Shenefelt, P., 379, 593
Sherman, S., 53, 145, 148, 158, 160, 178, 420, 582, 593
Shindler, K., 31, 238, 239, 582
Shor, R., 57, 248, 593
Shortliffe, L., 493, 499, 564
Siegel, D., 52, 73, 593
Siegel, R., 521, 593
Siegler, I., 133, 564
Silverstein, J., 500, 583
Simon, F., 500, 585
Simon, W., 518, 579
Simpkins, A., 69, 73, 74, 85, 593
Simpkins, C., 69, 73, 74, 85, 593
Singer, J., 124, 138, 159, 576, 591
Siuta, J., 249, 593
Skolnick, B., 83, 566
Smith, J., 499, 589
Soltani, M., 512, 585
Spanos, N., 53, 60, 75, 148, 151, 154, 177, 314, 344, 561, 587, 593
Sperry, R., 76, 594
Spiegel, D., 12, 49, 68, 82, 83, 94, 115, 136, 166, 168, 174, 175, 184, 187, 224, 231, 237, 239, 249, 303, 320, 347, 349, 360, 368, 369, 382, 394, 395, 418, 493, 499, 564, 576, 578, 579, 594
Spiegel, H., 49, 83, 165, 166, 168, 184, 237, 238, 239, 249, 250, 303, 320, 395, 594
Spinelli, E., 146, 148, 594
Spinhoven, P., 499, 594
Squire, L., 346, 594
Srivastav, A., 493, 560
Staats, J., 174, 587
Stam, H., 168, 588
Stanley, G., 85, 567
Stanley, R., 218, 219, 594
Stearns, V., 122, 568
Steen, T., 204, 210, 211, 592
Stegner, A., 117, 584, 594
Stephenson, R., 12, 106, 499, 584
Steptoe, A., 133, 594
Sterman, M., 77, 78, 594
Stevens, L., 78, 563, 595
Stewart, J., 106, 595
Stoessel, P., 86, 563
Strickner, S., 85, 573
Stroop, J., 70, 595
Stuss, D., 83, 595
Sugarman, L., 477, 486, 595, 597
Symons, B., 493, 499, 564
Szasz, T., 148, 595
Szechtman, H., 81, 595

T

Tan, G., 500, 595
Tart, C., 51, 182, 574, 595
Tasso, A., 8, 12, 166, 187, 583, 595
Tavris, C., 22, 158, 595
Teasdale, M., 493, 579
Teeley, A., 512, 585
Tellegen, A., 51, 166, 168, 595
Terr, L., 347, 595
Tharp, A., 116, 575
Thompson, B., 82, 395, 578
Thompson, K., 109, 339, 595
Thomson, L., 489, 595
Thornby, J., 500, 595
Tininenko, J., 512, 586
Tobis, I., 91, 595
Tomkins, D., 493, 566
Torem, M., 355, 373, 596
Torti, C., 430, 581
Tracy, R., 578
Treadway, M., 580
Trenter, E., 249, 563
Trevison, M., 68, 81, 257, 561
Tromp, E., 493–494, 596
Trosclair, A., 133, 596
Turner, M., 12, 586
Tury, F., 41, 560
Twenge, J., 214, 431, 596

U

Uleman, J., 48, 91, 596

V

Vaillant, G., 133, 205, 596
Vandenberg, B., 173, 596
Van Dyck, R., 499, 594
Van Eijk, J., 132, 587
Veith, R., 132, 564
Vendemia, J., 86, 505, 566
Verdali, H., 491, 597
Vermetten, E., 231, 573
Viviani, F., 499, 582
Vlieger, A., 493–494, 596

Voit, R., 22, 219, 343, 361, 596
Volckmann, P., 500, 585

W

Waalen, J., 172, 596
Wagstaff, G., 53, 165, 184, 319, 359, 399, 596
Waldman, K., 500, 595
Wallace, B., 83, 596
Ward, N., 68, 597
Wark, D., 41, 421, 597
Warner, D., 68, 81, 257, 561, 575
Warner, V., 491, 597
Wasserman, R., 580
Watkins, J., 5, 8, 38, 57, 109, 218, 219, 222, 251, 303, 306, 310, 314, 353, 366, 371, 379, 433, 480, 487, 488, 493, 504, 511, 561, 597
Watzlawick, P., 17, 59, 76, 100, 313, 422, 423, 597
Weakland, J., 422, 423, 597
Weekes, J., 58, 582
Wegner, D., 92, 597
Weichman, S., 499, 586
Weiner-Davis, M., 430, 597
Weissman, M., 491, 597
Weitzenhoffer, A., 14, 33, 65, 83, 90, 165, 166, 169, 183, 219, 222, 229, 242, 247, 248, 250, 304, 310, 366, 464, 465, 478, 479, 510, 511, 597
Wester, W., 43, 110, 348, 477, 493, 597
Wetterstrand, O., 129, 131, 597
Whisman, M., 420, 567
White, D., 69, 75, 597
White, P., 493, 580
Whitehead, W., 12, 586
Whitehouse, W., 228, 229, 567, 585
Whorwell, P., 122, 137, 500, 572, 583
Wickramaratne, P., 491, 597
Wickramasekera, I., 183, 587
Wiechman, S., 512, 586
Wild, M., 499, 598
Williams, J., 75, 598
Williams, L., 93, 598
Willis, L., 529, 578
Wilson, K., 503, 567
Wilson, R., 413, 598
Wilson, S., 166, 167, 598
Wilson, T., 92, 141, 144, 149, 560, 598
Winkel, G., 500, 583
Wohlhueter, A., 126, 568
Wolfkamp, S., 493–494, 596
Wood, C., 493, 598
Woody, E., 81, 595
World Health Organization (WHO), 428, 502, 598
Wright, C., 133, 594

X

Xie, M., 86, 505, 566

Y

Yapko, D., 224, 429, 481–482, 598
Yapko, M., 12, 18, 36, 43, 73, 85, 94, 100, 152, 169, 187, 214, 224, 263, 266, 289, 297, 315–316, 331, 339, 344, 347, 355, 378, 401, 416, 418, 428, 429, 430, 432, 433, 441, 464, 490, 491, 509, 511, 517, 519, 520, 581, 598, 599
Younger, J., 106, 562

Z

Zajac, R., 493, 499, 578
Zalsman, G., 493, 599
Zamansky, H., 83, 590
Zarren, J., 378, 415, 430, 599
Zeig, J., 17, 31, 52, 96, 99, 100, 161, 253, 254, 264, 267, 281, 282, 290, 291, 301, 319, 320, 331, 332, 344, 360, 361, 372, 404, 415, 421, 469, 470, 471, 473, 510, 555, 556, 600
Zerbini, L., 126, 568
Zimbardo, P., 166, 588
Zitman, F., 499, 594
Zoughbi, G., 499, 559
Zseni, A., 41, 560

SUBJECT INDEX

Note. *f* indicates figures, *t* indicates tables.

A

Abortion example, 39
Abreaction, 220–222
Absorption
  of children, 487–488
  fluctuations in, 186–187
  hypnotizability and, 168
  informal induction and, 325, 328
  introducing hypnosis and, 399–400
  self-, 214
  Spiegel on, 395
  suggestions and, 267, 325
  transderivational search in, 59–60
Abuse; *see also* Trauma
  changing personal history and, 417
  hypnotizability and, 156
  memory and, 224, 549
  safe place choice and, 310
  sexual, 347–349, 549
Acceptance, 106, 149–151
Accept and utilize formula
  compliments and encouragement, 287
  distractions and intrusions, 198–199, 201
  eliciting hypnotic experience and, 321
  experiential approaches and, 520
  negative response style and, 335
  resistance and, 322, 470–471, 472
  spontaneous regression and abreaction, 221–222
Accessing and contextualizing resources, 416
Accessing questions, 273–274
Active-alert hypnosis, 41–42, 421
Activity and rest cycle, 128–129
Acute pain, 496, 499, 502
Adaptability, 451–453
Adolescents, *see* Hypnosis with children and adolescents
Adrenaline experiment, 159
Advertising, 144–145, 157–158, 160–161
Affect
  bridging, 353
  ideoaffective responses, 60, 185, 265, 379–380, 381
  induction of, 369–370
  inner association of, 527
  pain and, 502–503, 509, 510
  priming and, 93–94
Affective reassociation, 527
Age
  responsiveness and, 173, 478–480, 487
  suggestions and, 480–482
Agency (personal connection), 407–408
Age progression
  age regression and, 353
  contextualizing resources and, 416
  description/applications of, 354–356
  eliciting, 356–359, 358*t*
  for pain management, 511
  sexual performance and, 436

Age regression
accessing resources and, 416
applications of, 348–349
changing personal history and, 417
critical incident process and, 419–420
dementia and, 175
description of, 345–346
dissociation and, 350, 371–372
eliciting, 349–353, 353*t*
hypnotizability and, 32, 36
memory and, 226, 227, 346–348, 350
for pain management, 511
present tense suggestions and, 286, 351
spontaneous regression and, 220–221
suggestion examples, 259, 261, 265, 269, 271, 272, 349–351
Airplane phobia, 413–414
Alcohol effects, 200
Alert hypnosis, 41–42, 421
Alerting clients, *see* Closure and disengagement
Alerting subsystem of brain, 69–70
Alpha state, 75
Alteration, sensory, *see* Sensory alteration
Altered state of consciousness (ASC), 34, 51–52
Ambiguous suggestions, 274
American Psychological Association (APA, Division 30), 5–6, 539–540
American Society of Clinical Hypnosis (ASCH), 219, 540
Amnesia
changing personal history and, 417
closure/disengagement and, 385
description/applications of, 359–361
dissociation and, 359–360, 361, 365, 368–369
eliciting, 362–365, 362*t*
hypnotizability assessment and, 35
negative hallucinations and, 374–375
for pain management, 511
posthypnotic, 90, 95, 272, 361–362
subjects prone to, 156, 168, 359
suggestion examples, 271, 362–363
Amnesia-prone hypnotic subjects, 156, 168, 359
Analgesia
description of, 365
dissociation and, 503
evidence for, 498, 499
kinesthetic modality and, 374
response set and, 296–297, 402
strategies for, 504–511, 504*t*
suggestion examples, 261, 262, 265
Anchors, 293–294, 417
Anesthesia
description of, 365
dissociation and, 503
history of hypnosis and, 497–498
strategies for, 504–511, 504*t*
touch and, 292
Anterior cingulated cortex, 81–82
Anticipation signals, 293–294, 316
Antidepressant medications, 429, 490–491
Anxiety
airplane phobia, 413–414
amnesia and, 362
of children, 490–491
communication and, 404–405
compliance and, 147
conformity and, 150
hypnotic phenomena and, 414*t*
insomnia and, 432
learning and, 116
medical hypnosis and, 107, 109
overview of, 427–428
pain management and, 396, 502
placebo effects on, 123
research findings, 136
sexual performance and, 435
suggestions and, 274–275
thinking ahead and, 354
APA (American Psychological Association, Division 30), 5–6, 539–540
Apposition of opposites, 274
Archaic involvement, 190–191
Arm catalepsy, 366, 367
Arm levitation
catalepsy and, 366
manual compounding and, 315
resistance and, 471
suggestion examples, 261, 265
time to respond and, 291
Arousal, 76
Artistry
communication and, 408–409, 556
dissociation and, 373
Lynn on, 546
research findings and, 239, 282, 284, 537, 550
of suggestions, 125, 400
treatment plan and, 390, 408–409
ASC (altered state of consciousness), 34, 51–52
ASCH (American Society of Clinical Hypnosis), 219, 540
Asch, Solomon, 150–151

As-if method, 190, 312–314
Assessment of children, 481
Assessment of responsiveness, *see* Hypnosis responsiveness assessment
Assignments, 420–422, 518; *see also* Follow-up for sessions
Associative experience
  affective reassociation, 527
  anchors and, 417
  cues as, 415, 522
  smoking and, 414–415
Astrology example, 269
Athletics, 117
Attention
  amnesia and, 363
  being stuck in hypnosis and, 40
  brain activity and, 65–66, 68–70, 74, 75, 77, 80, 82–83
  catalepsy and, 367
  conceptual framework and, 18–19
  consciousness and, 94–95
  in experiential approaches, 520, 521–522
  focusing methods and, 321–322, 532
  hypnotizability and, 80, 83, 167, 168
  impairments in, 200
  induction and, 302–303
  pain management and, 512–513
  selective, 68, 94–95, 167, 168, 184, 516
  sustained, 80
Attributional style of clinicians, 464
Attunement, 72–73, 254
Audio-recording
  as feedback for hypnotists, 294
  for follow-up, 307, 407–408, 511
Auditory anchor, 293–294
Auditory modality
  alterations of, 377
  binaural-beat sound stimulation and, 78
  internal/external focus and, 329–330
  pain quality and, 501
  preference for, 288–289
  relaxed scene and, 309
  suggestion examples, 269
Authoritarian suggestions, 259*t*, 270–271, 385
Authority experiment, 146–148
Automaticity; *see also* Ideodynamic responses
  brain activity and, 70–71
  dissociation and, 370
  in experiential approaches, 524–525
  ideodynamic responses and, 378, 379
  ideo-plasticity and, 131
  unconscious and, 91–94
Automatic talking/writing, 379
Avoidance, 136, 434, 490
Awakening for disengagement, *see* Disengagement and closure
Awake state; *see also* Everyday experiences
  alert hypnosis and, 41–42, 421
  everyday trances and, 34
  hypnotic phenomena in, 36
Awareness; *see also* Conscious functions; Consciousness
  altered states of, 34, 51–52
  conceptual framework and, 18–19
  dissociation and, 369
  in experiential approaches, 518–521, 524–528
  psychological characteristics of, 184–187
  transcript of session, 443–445

B

Barber, Theodore X., 53–54, 153–157
Basic rest-activity cycle, 128–129
Beach examples, 58, 309
Bedwetting, 481
Behavioral activation, 448–451
Behavioral medicine, *see* Hypnosis in behavioral medicine
Behavioral problems in children, 493
Beliefs of clients
  clinician-client relationship and, 96
  exploring, 22–24
  responsiveness and, 124, 125, 157
Believed-in imaginings
  as-if induction and, 312–313
  dissociation and, 185
  hallucinations and sensory alterations, 82, 375, 395
  role play as, 54–55
Believing in seeing experiment, 82, 395
Bell, meditation, 522, 528
Belongingness, 150
Bernheim, Hippolyte, 50, 122
Bias about hypnosis, 9–10, 112
Binaural-beat sound stimulation, 78
Bind of comparable alternatives, 274, 469
Biofeedback, 77–78, 130, 485
Biopsychosocial model
  Haley on, 469
  on health, 135
  mood and medicine, 131–133
  Spiegel and, 394
Bipolar disorder, 175
Blame, 108, 109
Blood flow, 109, 130

Bodily senses, *see* Kinesthetic modality; Proprioception; Sensory alteration; Sensory modalities
Boundaries, ego, 443–445
Brain in hypnosis, *see* Hypnosis and the brain
Brain plasticity, *see* Neuroplasticity
Brainwashing versus hypnosis, 38
Breast cancer, 137–138, 394, 395–396
Breast reduction surgery, 136
Breathing
  with children, 491
  in experiential approaches, 521, 524–528
  in hypnotic process, 305
  observing changes in, 193
Bridging, affect, 353
Bruxism, 110
Burn patients, 136
Business contexts, 116

C

Calibrated cycle, 151–152
Cancer
  breast cancer, 137–138, 394, 395–396
  case of Vicki, 3–4, 511–512
  hypnosis fear and, 298
  indirection with, 506–507
Candid Camera (television show), 145
Candlelight, 199
Cardiac health, 132–133
Cartesian Gap, 129
Catalepsy
  comfortable positions and, 305
  description/application of, 193–194, 365–367
  eliciting, 367–368
  expectations and, 152
  movement and, 194, 367–368, 487
  suggestion examples, 271
Catharsis, 348, 418–420
Causative predicate link, 295
Certification in hypnosis, 218–219
Chaining suggestions, 199, 201, 294–295, 315
Challenge tests of hypnotizability, 252
Changing personal history, 416–418, 436
Character, strengths of, 206
Charcot, Jean-Martin, 122
Checking in with clients, 194–195, 221, 404–405
Chemistry, having, 72–73
Chevreul's Pendulum test, 251–252, 251*f*
Childbirth, 111, 497–498, 504–505
Child development, 480–481
Children, *see* Hypnosis with children and adolescents
Choice of clients
  being stuck in hypnosis and, 40
  role of, 29–30
  treatment plan and, 272
  unconscious and, 102
Chowchilla Kidnapping case, 110, 113
Chronic pain, 496–497, 499, 502–503
Cigarette smoking, *see* Smokers
Clients
  checking in with, 194–195, 221, 404–405
  choice of, 29–30, 40, 102, 272
  clinician relationship with (*see* Clinician-client relationship)
  compliments for responses of, 286–287
  cooperation of, 260, 275, 295–296, 471
  drop outs, 398
  exploring beliefs of, 22–24
  investment of, 522
  language in sessions, 280, 284–285
  mirroring of, 254
  physical conditions of, 200–201
  responsibility of, 108, 109, 288, 518
  treatment decisions of, 12
Clinical practice; *see also* Artistry; Hypnosis session design and delivery
  age progression and, 355–356
  beliefs of client in, 22–23
  checking in with clients, 194–195, 221, 404–405
  with children, 173
  communication and, 15–17, 551
  contexts and, 105–106
  debriefing in, 151, 407
  deception recognition in, 227
  dissociation in, 373
  distractions in, 198–199, 201
  empowering patients in, 133–135
  Erickson on, 96–100
  ethical guidelines for, 232–233, 290, 292
  expectations and, 152, 169
  experiential learning in, 517–518
  focus and awareness in, 18–19
  group therapy/hypnosis, 248–249, 270, 394, 395–396
  guideline use, 279
  hypnosis and mindfulness, 520–521
  hypnosis as tool in, 42–43
  hypnosis informing, 8, 11
  hypnotizability assessed in, 35, 242, 244, 246–247
  hypnotizability enhanced in, 177–178

inductions, 308
informed consent for, 230–232, 290–291, 400
internal absorption of hypnotists in, 328
internal consistency in, 159–160
interpretation and, 415
medical hypnosis, 108–109, 133–135
nonconscious and conscious goals, 93
observation of others in, 192, 195
positive psychology and, 207, 209–211
preinduction talk and, 21, 80, 302
process versus content in goals, 439–440
psychotherapy, 118–119
relapse prevention, 222–223
respect for clients, 287
response sets, 297
sensitivity to words/phrases in, 59, 285–286
strengths and limitations focus, 175
suggestion styles, 262, 266–267, 270, 271
Clinician(s); *see also* Hypnotists
attributional style of, 464
being hypnotic, 390
brain functioning and, 81, 85
client relationship with (*see* Clinician-client relationship)
communication of, 161, 293–294, 322
Erickson on, 98
fear of control/responsibility, 30
flexibility of, 472–473
hazards of hypnosis and, 217–218, 219, 220, 223, 224, 227
illusion of invisible, 143–144
influence as inevitable, 17
power of, 30, 31, 37, 146–149
resistance and, 464
skills of, 391–392, 396
trauma training for, 221, 222
Clinician-client relationship
anticipation signals and, 293
Barber, T. on, 155
blame in, 108, 109
brain activity and, 72, 73–74
clarity and certainty needs in, 145–146
environment and, 198
expectations and, 151–152, 157
as hypnosis foundation, 8, 9, 16, 21
hypnosis hazards and, 218
hypnosis in first session and, 399
illusion of invisible clinician, 143–144
positive psychology and, 178–179
power and, 29–30, 146–149
preinduction talk and, 21, 80, 302
responsiveness and, 251
Sheehan on, 190–191
special interactional outcomes and, 52–53
Spiegel on, 396
values/beliefs and, 96
Closure and disengagement
client time for, 291, 385, 406
in experiential approaches, 528
overview of, 384–385
suggestions for, 406–407
Cognitive-behavioral approaches, 378, 413
Cognitive dissonance, 157–161, 212–213, 431
Cognitive processes; *see also* Hypnosis and the mind
brain activity and, 69–71, 83
compliance and, 160
cybernetics and, 113
flexibility in, 187
hypnotizability and, 80, 83, 177
ideocognitive responses, 60, 378, 380, 381
multidimensional, 90–91
in neodissociation model, 48–49, 184–185
new unconscious, 91–94
pain management and, 509, 512–513
sociocognitive perspective on, 53
Collaboration and resistance, 466
Color perception, 82, 395, 396
Comfort, physical, 200, 221, 305
Common factors viewpoint, 517–518
Communication; *see also* Hypnosis session guidelines; Hypnosis suggestions
artistry and, 408–409, 556
being hypnotic and, 517
in business context, 116
check-ins and, 404–405
of clinicians, 161, 293–294, 322
as conceptual framework, 15–17, 551
conditioning property of words, 58–60
evocativeness of, 283
as focus, 8, 21
hypnotizability tests and, 252–254
in induction, 328–329
multiple-level, 331
nonverbal, 293–294, 322, 368, 381, 517, 554–555
pacing statements, 328–329
power of hypnotic, 257
reframing and, 423
relationship problems and, 430, 431
resistance as, 470
self-image of client and, 173–174
suggestion structure/style and, 258–266, 259*t*, 277

with unconscious of clients, 100
words and meanings, 99, 171, 285–286
Zeig on, 555
Compartmentalization, 458–461
Compliance
authoritarian suggestions and, 271
cognitive consistency and, 160
with Erickson, 290–291
hypnosis compared to, 55, 148
with medical treatment, 122
in obedience experiment, 146–148
Compliments for positive responses, 286–287
Compounding techniques, 199, 201, 294–295, 315
Compulsion, 90
Conceptual framework; *see also* Hypnosis theories
client-clinician communication as, 15–17, 551
clinician skills and, 391
focus/awareness and, 18–19
hypnosis and experiential approaches, 515–516
hypnosis as tool and, 42–43
Confabulation, 224, 228–229, 347–348, 370
Conflict reduction, 70–71
Conformity
perception experiment on, 150–151
safety and, 101
stage hypnosis and, 27–28
uncertainty and, 145–146, 159
Confusional suggestions; *see also* Confusion techniques
age regression and, 353
amnesia and, 364
guidelines for, 280
overview of, 274–275
for pain management, 509–510
in session transcript, 453–455
Confusion techniques
overview of, 336–340, 337*t*, 338*t*, 340*t*
in pain management, 338–339, 509–510
suggestions (*see* Confusional suggestions)
Conscious functions
amnesia and, 363–364
brain activity and, 76
confusion techniques and, 337, 338–339
criminal investigations and, 110
dissociation and, 371
Erickson on, 331–332
in experiential approaches, 524–525
goals and, 93
overview of, 94–95
posthypnotic amnesia and, 90, 95
posthypnotic suggestions and, 272
session transcripts on (*see* Hypnosis session transcripts)
suggestions and, 89, 95, 263–264, 266, 269–270, 279–280
Consciousness
altered state of, 34, 51–52
attention and, 94–95
Barber, T. on, 153–154, 157
mirroring of client and, 254
Constricted experience of time, 382–383
Content and process
in goals, 439–440
of mindfulness, 521–523
Content suggestions
in experiential approaches, 525
group hypnosis and, 270
induction and, 309, 325
overview of, 259*t*, 267–268
Contexts, *see* Hypnosis contexts
Contextualization; *see also* Posthypnotic suggestions
of client resources, 416
in experiential approaches, 523, 527–528
suggestions and, 259*t*, 272–273, 393, 404–405
Continua of hypnosis suggestions, 258, 259*t*, 400
Control
children and, 494
client education on, 80
homework and, 422
hypnotic patterns and, 344
medical hypnosis and, 107
misconceptions and, 22, 24–25, 26, 27–28, 29–30, 31, 36–38
need for internal consistency and, 158–159
negative suggestions and, 334–336
physical, 117
resistance and, 466
self-hypnosis and, 39–40
therapeutic themes and, 403
transcript of session, 458–461
Conversational induction, *see* Hypnosis induction with conversational strategies
Cooperation
covering all possibilities and, 275
resistance and, 471
suggestions and, 260, 295–296
Coping, avoidant, 434, 490

Countdown
for closure/disengagement, 385
in induction, 312, 319
in progressive muscle relaxation, 307
Courtroom testimony, *see* Hypnotic testimony
Covering all possibilities, 275
CPGHE (Creative Psychosocial Genomic Healing Experience), 129–130, 131
Crawford, Helen J., 79–81
Creative Psychosocial Genomic Healing Experience (CPGHE), 129–130, 131
Criminal investigations, 110, 113–115
Critical incident process, 418–420, 419*t*
Cues
associational, 415, 522
hypnotic voice as, 317
meditation bell, 522, 528
minimal, 253–254
rapid induction signal, 37
Cutting in line experiment, 160
Cybernetics, 113
Cycles
calibrated, 151–152
90-120 basic rest-activity, 128–129

D

Daily living experiences, *see* Everyday experiences
Deafness, 529–530
Deautomatization in Stroop test, 70–71
Debriefing, 151, 407
Deception, 123–125, 227
Deepening techniques
catalepsy and, 367
overview of, 314–317
suggestion examples, 259, 271, 275
Deep hypnosis, 182, 191, 258
Deep Muscle Relaxation, 307–308
Defense mechanisms, 100–101
Delivering hypnosis interventions, *see* Hypnosis session design and delivery
Delusions, 90
Demand characteristics, 151, 226–227
Demeanor, 293–294, 517
Dementia and hypnotizability, 174–175
Dental hypnosis, 109–110, 170–172
Dependency, 39–40, 141–142, 149
Depression
bipolar disorder, 175
childhood, 485, 490–491
clarification example, 285
expectations and, 152
happiness exercises for, 210–211
health and, 132–133
homework example, 421–422
hypnotic phenomena and, 414*t*
insomnia and, 119, 432
metaphors and, 441
neuroplasticity in, 86
overview of, 428–429
placebo effects on, 123
self-absorption and, 214
Derived meanings, *see* Transderivational search
Descending stairs technique, 314–315
Designing hypnosis interventions, *see* Hypnosis session design and delivery
Development of children, 480–481
Directives, implied, 275
Direct suggestions
age progression and, 357
amnesia and, 362–363
catalepsy and, 367
choice of, 400–401
for closure/disengagement, 384–385
for dissociation, 371–372
in experiential approaches, 524, 525, 526, 527
for hallucinations, 376
for ideodynamic responses, 380
overview of, 259*t*, 261–263
for pain management, 504–505, 510–511
for smoking, 404
of symptom abatement, 416
for time distortion, 382–383
Discomfort and checking in, 221
Discovery, guided, 518
Disengagement and closure
client time for, 291, 385, 406
in experiential approaches, 528
overview of, 384–385
suggestions for, 406–407
Displacement of pain, 508–509
Dissociation
age regression and, 350, 371–372
amnesia and, 359–360, 361, 365, 368–369
automaticity and, 370
brain activity and, 69
confusion techniques and, 336
description of, 368–369
eliciting, 371–373
in experiential approaches, 524, 525, 526, 527
fear of flying and, 413
Hilgard on, 245

hypnotizability and, 168
ideodynamic responses and, 380
motion and, 194
neodissociation model, 48–49, 69, 184–185, 243–244
nonvoluntary responding and, 302–303
overview of, 184–185
pain management and, 369, 371, 373, 445–448, 503, 507–508
relaxation and, 192
Rossi on, 129–130
sexual problems and, 435
stage performers and, 369–370
substance abuse and, 414–415, 414*t*, 434
transcript of session, 445–448
Dissonance, cognitive, 157–161, 212–213, 431
Distractions
acceptance and use of, 198–199, 201
for pain management, 512–513
Divorced parents example, 352–353
Dizziness, 194
Doctor-patient relationship, *see* Clinician-client relationship
Domain of hypnosis, 90
Double-binds, 274, 469
Drop outs, 398
Drug effects, 200; *see also* Medications
Dual induction, 171, 172, 339
Dynamics, hypnosis treatment, 439–442, 441*t*, 442*t*; *see also specific dynamics*

E

EAT (Experiential Analysis Technique), 183, 189
Eating at restaurant example, 60
Eating Meditation, 522–523
Eclecticism and hypnosis theories, 47–48, 60
Education contexts, 115–116
EEG (electroencephalography), 66, 67, 74–78
EEG entrainment, 78
Ego boundaries, 443–445
Ego state therapy, 370–371
Electroencephalography (EEG), 66, 67, 74–78
Elephant behavior, 171
Elevator technique, 314–315
Embedded questions, 357–358
Embedded suggestions
age progression and, 357–358
metaphors with, 330–334
in mindful meditation transcript, 524–528
overview of, 253–254
for pain management, 506–507
EMDR (Eye Movement Desensitization and Reprocessing), 530–532
Emotion(s); *see also* Affect
expectations and, 151
false memory and, 370
hazards of hypnosis and, 39
pain and, 502–503, 509, 510
priming and, 93–94
role playing and, 56
transcript of session, 458–461
Emotional intelligence, 477
Emotional problems in children, 493
Emotional self-regulation of children, 491
Empathy, 72–73, 74, 254
Empirically supported treatment (EST), 238, 548–549; *see also* Research on hypnosis
Empowerment
agency and, 407–408
in behavioral medicine, 133–135
depression and, 429
Erickson on, 98
ethical issues and, 233
as goal, 288
mindfulness and, 528
misconceptions and, 520–521
owning the solution and, 518
relaxation and, 306
unconscious functions and, 95
Encopresis, 479–480, 493
Enlightenment, 518–521
Enuresis
Erickson and, 487–488
responsiveness and, 479–480, 493
suggestions and, 481
Environment, 125–126, 197–199
Epigenetics, 125–126, 127–128, 129, 130–131
Epinephrine experiment, 159
Erickson, Milton H.
compliance with demands of, 290–291
on confusion techniques, 338–339
enuresis and, 487–488
on hypnosis with children, 475, 479, 481
indirect suggestions and, 554–555
influence of, 552
metaphorical approaches and, 331–332
overview of, 96–100
on pain management, 506–507
pantomime technique of, 529–530
on pseudo-orientation in time, 356
on resistance, 470–472
Rossi and, 128, 129
Thompson and, 170, 171
on unconscious, 331–332, 361

utilization approach of, 52–53, 264
Zeig on, 282–284
Erickson Foundation, *see* Milton H. Erickson Foundation
Ericksonian approach; *see also specific phenomena and principles*
accept and utilize principle, 287
on amnesia, 360–361
depth of hypnosis and, 314
Eye Movement Desensitization and Reprocessing and, 532
Hilgard on, 245
on hypnotic phenomena, 343–345
induction and, 306, 320–321
metaphor and, 331–332
mind-body healing and, 130
overview of, 52–53, 96–100, 264, 551, 556–557
Rossi and, 128, 129
Zeig on, 282
ERPs (event-related potentials), 67, 70–71, 78, 81
ERS (eye-roll sign), 249–250
EST (empirically supported treatment), 238, 548–549; *see also* Research on hypnosis
Ethical issues
guidelines, 232–233, 290, 292
in medical hypnosis, 108
Event-related potentials (ERPs)
EEG and, 67
research findings, 70–71, 78, 81
Everyday experiences; *see also* Awake state
age regression, 346
amnesia, 360
dissociation, 369, 371
hallucinations, 375
hypnotic phenomena and, 343–344, 535
observation of, 386
spontaneous hypnosis, 366
time distortion, 382
trances, 34
Evolution of Psychotherapy Conferences, 281
Exclusion rule, per se, 231
Executive functions
brain activity and, 69–71
in neodissociation model, 48–49, 184–185
Exercise in imagination, 157
Exhibitionism and stage hypnosis, 25–28
Expanded experience of time, 382–383, 384
Expectations
hypnosis in first session and, 399
hypnotizability and, 168–169, 240
induction and, 157, 169, 319–320
Lynn on, 546
overview of, 184
power of, 151–152, 157
responsiveness and, 124, 125, 157
suggestibility tests and, 252
therapeutic response and, 354
Experience of hypnosis, *see* Hypnosis phenomenology
Experiential Analysis Technique (EAT), 183, 189
Experiential approaches
content and process of mindfulness, 521–523
experiential learning in therapy, 517–518
guided mindful meditation transcript, 524–528
guided processes and hypnosis, 518–519
homework as metaphor, 421
hypnosis compared to, 515–516, 524–528
nonverbal, 529–532
overview of, 532–533
stages of hypnosis in, 523
suggesting awareness and enlightenment, 518–521
Experiential learning, 211, 517–518
External/internal orientation, 328–330, 464
Eye(s), tears in, 193
Eye catalepsy, 152, 366
Eye closure
children and, 487
eye-fixation techniques, 310–311
fluttering and, 193
suggestions for, 261, 264–265, 271, 305
Eye closure, mind's, 315–316
Eye-fixation techniques, 310–311
Eye Movement Desensitization and Reprocessing (EMDR), 530–532
Eye-roll sign (ERS), 249–250
Eye-roll test, 249

F

Facts of life example, 23
Failure to remove suggestions, 229
Failure to respond, *see* Negative/minimal response to suggestions
False memory
age regression and, 226, 346–348
amnesia and, 359–360, 361
emotions and, 370
influence of controversy on, 549
legal issues with, 110, 230
Lynn on, 547

Familiarity and advertising, 144–145
Family therapy, 469
Fantasy, 155, 167, 189
Fatigue effects, 200
Fear
  of clinicians, 30
  of flying, 413–414
  of hypnosis, 298, 465–466
  pain management and, 502, 505
Feedback, biological, *see* Biofeedback
Feedback from clients
  communication and, 404–405
  on eye closure, 311
  individual differences and, 409
  on relaxed scene choice, 308, 310
  on suggestions, 280
Feedback from recordings, 294
Feelings, *see* Affect; Emotion(s)
Fidgeting
  of children, 194, 487
  negative suggestions and, 335, 336
Finger snaps, 317, 385
Five Factor model, 166–167
Flexibility
  of clinicians, 472–473
  in cognition and perception, 187
  transcript of session, 451–453
Fly buzzing scale, 183
fMRI, *see* Functional magnetic resonance imaging
Focus, *see* Attention
Follow-up for sessions, 307, 407–408, 511; *see also* Homework
Forensic hypnosis
  accuracy of report and, 190–191
  false memory and, 110, 230
  hypnotic testimony, 114–115, 191, 226, 227, 231, 347–348
  lawsuits and secondary gains of pain, 501
  overview of, 110, 113–115
Foresight and prevention, 354
Forewords/introductions (previous), 545–558
  1st Edition, 554–558
  2nd Edition, 550–554
  3rd Edition, 545–550
Formal strategies of induction, *see* Hypnosis induction with formal strategies
40 hertz band, 76
Four-stage creative process, 130
Framing of metaphors, 333–334, 425
Free will, *see* Will
Friendship, 228; *see also* Relationships
Frontal brain regions
  attention and, 69, 82–83
  in hypnosis, 75, 79–80
  hypnotizability and, 77
Frustration tolerance and drop outs, 398
Functional magnetic resonance imaging (fMRI)
  description of, 67–68
  research findings, 70–71, 80
  Spiegel and, 395
Furniture, 199
Future orientation, 99, 356, 448–451

G

Gastrointestinal disorders, 136–137
Gender, 169, 170, 172
Gene chips, 126
Gene expression
  environment and, 125–126
  future directions on, 130, 512
  Rossi on, 127–128, 129
  suggestions and, 73–74, 126
Generalized reality orientation, 56–57
Gene therapy for pain, 512
Gift wrapping of suggestions, 283
Glove anesthesia, 505–506
Goal(s)
  deliberativeness about, 393, 396–397
  empowerment as, 288
  first priorities, 397–398
  nonconscious versus conscious, 93
  process versus content in, 439–440
  in psychotherapy, 411–412
  risk factors as, 398
  strategic design of sessions and, 392–393
  transcript of session, 448–451
Goal orientation, 448–451
Gratitude visit, 210, 213–215
Grouch story, 204–205
Group therapy/hypnosis
  for breast cancer, 394, 395–396
  suggestions and, 270
  susceptibility scale for, 248–249
Guided discovery, 518
Guided experiential processes
  hypnosis and, 518–519
  imagery and herpes-simplex virus-2, 137–138
  mindful meditation transcript, 524–528
Guidelines, *see* Hypnosis session guidelines
Guides, hypnotists as, 301

H

Habit disorders in children, 493
Habit formation, 91
Haley, Jay, 467–470
Hallucinations
  brain activity and, 81–82
  color perception and, 82, 395
  description/application of, 373–375
  dissociation and, 369–370
  eliciting, 376–377
  hypnotizability tests and, 252
  images and, 190
Hand Clasp test, 252–253
Hand mirroring approach, 129–130
Handshake Technique, 366
Happiness, 208–209, 210–211, 212–215
Harmony, 157–161
Harvard Group Scale of Hypnotic Susceptibility (HGSHS), 248–249
Hazards of hypnosis, *see* Hypnosis hazards
Headaches, 108, 124–125, 194, 221
Healing, 108–110, 128–130, 136
Health, 132–133, 135; *see also* Mental health
Health Frontiers, 483–484, 485
Heavy arm, 471
Helplessness and metaphors, 441
Hemihypnosis, 76
Herpes-simplex virus-2 (HSV-2), 137–138
HGP (Human Genome Project), 125
HGSHS (Harvard Group Scale of Hypnotic Susceptibility), 248–249
Hidden observer
  hallucinations and, 377
  Hilgard on, 185, 243–244, 245
Highway hypnosis, 323
Hiking example, 421–422
Hilgard, Ernest (Jack)
  on hidden observer, 185, 243–244, 245
  neodissociation model of, 48–49, 69, 184–185, 243–244
  in session transcript, 451–453
  Weitzenhoffer and, 33, 34, 69, 243, 247
HIP (Hypnosis Induction Profile), 239, 249–250, 395
Holy Grail of hypnosis, 516–517
Homework, 420–422, 518; *see also* Follow-up for sessions
Honest liar syndrome, 114
Horoscopes example, 269
Hot Object Test, 252
HPV (human pappillomavirus), 137
HSAQ (Hypnotic State Assessment Questionnaire), 240
HSV-2 (herpes-simplex virus-2), 137–138
Hull, Clark, 238
Human Genome Project (HGP), 125
Human pappillomavirus (HPV), 137
Humor, 276, 453–455, 457–458
Hypermnesia
  age regression and, 348–349
  critical incident process and, 419–420
  definition of, 345, 346
Hypertension and stress, 107
Hypnos, 40–41
Hypnosis; *see also specific hypnosis topics*
  being hypnotic versus, 71–72, 390, 517
  compliance compared to, 55, 148
  definition of, 5–7, 13–14, 65, 90, 113, 469, 516
  evidence-based effectiveness of, 7, 10–12, 34–35
  focus and awareness, 18–19
  Holy Grail of, 516–517
  labeling and, 14
  neurological signature for, 65, 70, 82, 282
  as nondeceptive placebo, 124, 355
  rationale for, 89, 211
  reactions to idea of, 7–8, 9–10, 13, 112, 298, 465–466, 520–521
  stages of interaction, 301–302, 302*t,* 318
  substitute terms for, 297–298
  suggestibility compared to, 142
  as therapeutic tool, 42–43
Hypnosis across modalities, 515–533
  content and process of mindfulness, 521–523
  experiential learning in therapy, 517–518
  guided experiential processes and, 518–519
  Holy Grail of hypnosis, 516–517
  hypnosis versus being hypnotic, 517
  mindful meditation transcript, 524–528
  mindfulness and hypnosis, 518–521
  nonverbal experiential approaches, 529–532
  overview of, 515–516, 532–533
  stages of hypnosis in experiential approaches, 523
Hypnosis in behavioral medicine, 121–138; *see also* Hypnosis in pain management; Medical hypnosis
  catalepsy and, 367
  children and, 484–485, 493–494

conditions treated, 135–138
empowering patients, 133–135
epigenetics, 125–126, 127–128, 129, 130–131
history of, 497–498
mood, 131–133
overview of, 121–122, 138
placebo and nocebo effects, 122–125
Rossi, Ernest L., 127–130
Spiegel and, 394–396, 397
Hypnosis and the brain, 63–86
attention, 65–66, 68–70, 74, 75, 77, 80, 82–83
automatic processing, 70–71
clinical applications, 85–86
contradictory findings on, 83–85
Crawford, Helen, 79–81
deafness and, 529–530
Eye Movement Desensitization and Reprocessing and, 531, 532
mirror neurons, 71–74
modular unit model, 49–50
neurogenesis, 73, 85–86
neurological health, 133
neuroplasticity, 73, 85–86, 128–130, 131, 503
overview of, 63–64
pain management, 64–65, 79–80, 81, 82, 498, 503, 512–513
rationale for research, 64–66
research findings, 71–78, 81–85, 395
research technologies, 66–68, 84–85, 549
Sheehan on, 191–192
Zeig on, 282
Hypnosis with children and adolescents, 475–494
age-appropriate suggestions, 480–482
age differences in responsiveness, 173, 478–480, 487
childhood depression, 485, 490–491
childhood stressors and, 476–477, 484
conditions treated, 492–494
deaf children, 529
engaging with children, 482, 486
experience of hypnosis, 486–488
fidgeting and, 194, 487
methods for, 488–489, 491–492
Olness, Karen, 483–485, 486
overview of, 475, 494
rationale for, 477–478
Hypnosis contexts, 105–119; *see also specific contexts*
business, 116
dentistry, 109–110, 170–172
education, 115–116
everyday experiences, 343–344
forensics, 110, 113–115
Kroger, William S., 111–113
medicine, 106–109
overview of, 105–106
psychotherapy (*see* Hypnosis in psychotherapy)
sports, 117
stage performers, 106
Hypnosis environments and physical conditions, 197–201
environmental variables, 197–199
physical variables, 200–201
Hypnosis hazards, 217–229
clinicians and, 217–218, 219, 220, 223, 224, 227
consumer decisions and, 12–13
critical incident process and, 419, 420
innate hazards, 218
in medical hypnosis, 108, 134–135
mind and, 100–101, 102
misconceptions on, 38–39, 217
negative experience effects, 326
negative self-appraisal, 37
optimism as, 134–135
Orne, Martin T., 225–228
overview of, 217–218, 219–224, 228–229
scripts and, 321
in stage hypnosis, 26, 27, 28
suggestion types and, 260, 268, 335
training/certification and, 218–219
Hypnosis induction; *see also specific hypnosis induction topics*
of affect, 369–370
as-if method and, 312–313
brain activity and, 64–65, 70, 75
children and, 487, 488, 492
conscious mind and, 95
cues and, 37
definition of, 6
dissociation and, 371–373
dual induction, 171, 172, 339
expectations and, 157, 169, 319–320
in experiential approaches, 525
hypnotic phenomena and, 41
hypnotizability and, 32, 36, 241
inner sage, 391
Kroger on, 113
misconceptions and, 37
overview of, 301–302, 302*t*, 402
preinduction talk and, 21, 80, 302
in psychotherapy, 118–119

resistance and, 313–314, 322, 327, 330
sociocognitive views on, 54
standardizing, 176, 303–304
Hypnosis Induction Profile (HIP), 239, 249–250, 395
Hypnosis induction with conversational strategies, 319–340
Barber, T. on, 155
confusion techniques, 336–340, 337*t*, 338*t*, 340*t*
conversation to induction, 321–323, 323*t*
formal experience used, 323–324, 325–327
imposing versus eliciting hypnosis, 320–321
informal experience used, 323, 324–325
internal focus used, 328–330
metaphors with embedded suggestions, 330–334
negative suggestions, 334–336
overview of, 319–320, 340, 402
storytelling, 425
Hypnosis induction with formal strategies, 301–318
as-if method, 312–314
auditory anchor and, 294
beginning, 305–306
conversational strategies and, 325–327
counting methods, 312, 319
eye-fixation techniques, 310–311
hypnotizability and, 36, 319–320, 321
intensifying techniques, 314–317
overview of, 301–305, 302*t*, 317–318, 402
progressive muscle relaxation, 306–308
relaxed scene experience, 308–310
shifting approach in, 304
Thompson on, 172
Hypnosis and the mind, 89–102; *see also* Cognitive processes; Mind-body relationships
clinical framework, 15
conscious and unconscious characteristics, 94–96, 100
defenses of mind, 100–101
Erickson, Milton, 96–100
memory, 43–44
mind-clearing/focusing strategies, 433
mind's eye closure, 315–316
misconceptions, 22, 24–25, 36–38, 43–44
multidimensional processing, 90–91
myth on power of unconscious, 101–103
new unconscious, 91–94
overview of, 89, 103
Hypnosis misconceptions, 21–44
beliefs of client explored, 22–24
clinician fear of responsibility and, 30
on control, 22, 24–25, 26, 27–28, 29–30, 31, 36–38
memories and, 43–44, 116
mindfulness and, 520–521
overview of, 30–32, 36–44, 217
responding to, 23, 24, 29–30
stage performers and, 10, 13, 14, 24–28, 37
staging for information on, 21–22
on unconscious, 101–103
Weitzenhoffer, André M., 33–35
Hypnosis organizations
American Society of Clinical Hypnosis (ASCH), 219, 540
Institute of Experimental Psychiatry Research Foundation, 226
International Society of Clinical Hypnosis (ISH), 540–541
Milton H. Erickson Foundation, 98, 281, 282, 541–542
National Pediatric Hypnosis Training Institute (NPHTI), 542
Society for Clinical and Experimental Hypnosis (SCEH), 219, 541
Society of Psychological Hypnosis (APA Division 30), 5–6, 539–540
Hypnosis in pain management, 495–513
anxiety and, 396, 502
brain activity and, 64–65, 79–80, 81, 82, 498, 503, 512–513
with children, 493–494
complexity of pain and, 496–497
confusion techniques for, 338–339, 509–510
control and, 107
in dentistry, 109, 171
dissociation and, 369, 371, 373, 445–448, 503, 507–508
of Erickson, 97
evidence and conditions treated, 498–500
future possibilities, 512–513
hallucinations and, 377
history of, 497–498
hypnotizability scales and, 244
internal/external focus and, 329–330
interview on subjective experience, 500–503
overview of, 495, 512, 513
placebo effects, 123, 124–125
radiological procedures, 136
Spiegel on, 396

strategies for, 504–511, 504*t*
structure for, 503–504
Thompson on, 171
time distortion and, 382
touch and, 292
transcript of session, 445–448
treatment choices for, 86
Vicki's case and, 3–4, 511–512
Hypnosis phenomena, 343–386; *see also specific phenomena*
age progression, 354–359, 358*t*
age regression, 345–353, 353*t*
amnesia, 359–365, 362*t*
analgesia and anesthesia, 365
in awake state, 36
catalepsy, 365–368
client time to respond and, 291
closure and disengagement, 384–385
definition of hypnosis and, 516
dissociation, 368–373
hallucinations and sensory alterations, 373–377
ideodynamic responses, 378–381
induction and, 41
overview of, 343–345, 345*t*, 386
in psychotherapy, 118
symptoms and, 412–414, 414*t*
time distortion, 381–384
Hypnosis phenomenology, 181–196
checking in with clients, 194–195
instruments for research, 182–183
overview of, 181–182, 195–196, 195*t*
physical characteristics, 192–194, 195*t*
psychological characteristics, 184–187, 195*t*
responsiveness and, 167–168
Rossi on, 130
Sheehan, Peter, W., 188–192
uniqueness of individuals, 182
Hypnosis and positive psychology, 203–215
accessing/contextualizing resources in, 416
clinician-client relationship and, 178–179
definition/development of, 204–207
key aspects of, 207–208
overview of, 18, 19, 203–204, 215
role for hypnosis, 211–215
therapy in, 209–211
Hypnosis in psychotherapy, 411–436
assumptions on, 412*t*
common clinical concerns, 426–431
Erickson on, 282
flexibility and, 187
Haley, Jay, 467–470
informed consent for, 230–232, 290–291, 400
metaphors and, 441*t*
Orne on, 228
overview of, 117–119, 411, 426, 436
patterns of intervention, 415–426, 419*t*
positive psychology, 209–215
repetitive problem themes, 411–412
self-esteem problems, 431–436
symptoms and hypnotic phenomena, 412–414, 414*t*
Hypnosis responsiveness, 165–179
age and, 173, 478–480, 487
assessment of (*see* Hypnosis responsiveness assessment)
Barber, T. on, 53–54
beliefs and expectations, 124, 125, 157
brain activity and, 68
conscious analysis and, 280
in definition of hypnosis, 6
different capacities for, 165–166
enhancing, 176–178
enuresis and, 479–480, 493
mental status and, 174–175
mind-body relationships and, 131
misconceptions and, 31–32
overview of, 178–179
personality and, 166–169, 175–176
self-directedness and, 141–142
self-esteem and, 173–174
stage hypnosis and, 26
suggestibility and, 186
Thompson, Kay F., 170–172
trance state-specific, 272
Zeig on, 281–282
Hypnosis responsiveness assessment, 237–255
clinical/experimental divide, 237–239
functions of hypnotizability tests, 35, 246–247
Hilgard, Ernest R., 243–245
hypnotizability as measure, 32, 36, 80, 166, 228, 239–242, 245
informal tests for, 250–254
standardized instruments for, 183, 247–250
standardized testing cons, 35, 241–242, 245
standardized testing pros, 239–241, 244–245
tips on, 254–255
Yapko on, 245–246
Hypnosis session design and delivery, 389–409; *see also* Hypnosis session guidelines
art of, 408–409
clinician skills, 391–392
first priorities, 397–398

follow-up for sessions, 307, 407–408, 511
generic structure for sessions, 401–407, 401*t*
hypnosis in first session, 399
hypnosis versus being hypnotic, 390
hypnotic style and, 400–401
introducing hypnosis, 399–400
overview of, 389–390
risk factors as goals, 398
Spiegel, David, 394–396, 397
strategic design, 392–393
targets of treatment, 393, 396–397
Hypnosis session guidelines, 279–299; *see also* Hypnosis session design and delivery
anticipation signals of intentions, 293–294, 316
chain suggestions structurally, 294–295
client defining terms experientially, 285
clients informed, 290–291
clients' language used, 280, 284–285
client time to respond, 291
compliment/encourage positive responses, 286–287
ethical issues, 232–233
overview of, 298–299, 299*t*
present tense/positive structure, 286
problem ownership and resources, 288
process suggestions for projections, 295–296
response set built, 296–297
sensory modality preferences, 288–289
simplicity of suggestions, 279–280
substitute terms for hypnosis, 297–298
touch selective and permitted, 292
Zeig, Jeffrey K., 281–284
Hypnosis session transcripts, 442–462
adaptability, 451–453
compartmentalization, 458–461
goal orientation, 448–451
overview of, 442–443, 461–462
pain management, 445–448
self-definition and care, 443–445
stress management, 455–458
weight management, 453–455
Hypnosis suggestibility; *see also* Hypnosis responsiveness; Hypnotizability
definition of, 34
expectations and, 252
gullibility versus, 101
hypnosis compared to, 142
hypnotizability compared to, 168, 237
memory problems and, 228–229
responsiveness and, 183, 186
social psychology of (*see* Social psychology of suggestibility)
Hypnosis suggestions; *see also specific types of suggestions*
absorption and, 267, 325
age and, 480–482
amnesia and, 271, 362–363
artistry of, 125, 400
in behavioral medicine, 122
brain activity and, 64–65, 68, 69, 73–74, 77
in business context, 116
chaining, 199, 201, 294–295, 315
for closure and disengagement, 406–407
communication style and, 161
complexity of, 280
conscious/unconscious and, 89, 95
as creating possibilities, 94, 134–135
definition of, 34, 169
in definition of hypnosis, 6
epigenetic effects of, 73–74, 126
Ericksonian approach and, 264, 321
failure to remove, 229
gift wrapping of, 283
guidelines for (*see* Hypnosis session guidelines)
hypnosis as good thing and, 31
hypnotizability and, 32, 36
internal/external orientation and, 328–329
intrusions and, 199
Kroger on, 112–113
Lynn on, 546
measurement of responsiveness to, 183, 186
memory problems and, 224
mind-body relationships and, 131
negative response to (*see* Negative/minimal response to suggestions)
for pain management, 502, 503, 504–505, 506, 507, 508–510
passive/permissive view and, 50–51
placebo effects and, 124–125
power to choose and, 29–30
in psychotherapy, 117–119
reality and, 226
resistance and, 465, 466
self-esteem and, 173
simplicity of, 279–280
stage hypnosis and, 26, 28
structure and style (*see* Hypnosis suggestions structure and style)
themes addressed by, 404, 405
trauma management and, 222
unintended interpretation of, 220

Hypnosis suggestions structure and style, 257–277
acceptance/rejection of suggestions, 258
continua of, 258, 259*t*, 400
direct or indirect, 266–267, 400–401, 473
guidelines for (*see* Hypnosis session guidelines)
overview of, 257, 258–266, 259*t*, 267–273, 277
specialized suggestions, 273–276
Hypnosis theories, 47–60; *see also specific theories*
altered state of consciousness (ASC), 51–52
clinician-client communication and, 15–17
conditioning property of words/experiences, 58–60
eclecticism and, 47–48, 60
focus/awareness and, 18–19
hypnosis as tool and, 42–43
individual differences and, 99
neodissociation model, 48–49, 69, 184–185, 243–244
passive/permissive view, 50–51
psychobiological, 49–50
reality-testing view, 56–58
response set theory, 168
sociocognitive, 53–56
special interactional outcomes, 52–53
Hypnosis treatment dynamics, 439–442, 441*t*, 442*t*; *see also specific dynamics*
Hypnosis virtuosos, 31, 248
Hypnotherapy
Kohen and Olness on, 492
overview of, 11
research and, 549
schools of therapy and, 42–43
Zeig on, 283
Hypnotic State Assessment Questionnaire (HSAQ), 240
Hypnotic testimony
memory and, 114–115, 191, 347–348
Orne on, 226, 227
per se exclusion rule and, 231
Hypnotism, 165
Hypnotists; *see also* Clinician(s)
being hypnotic, 390
client relationship with (*see* Clinician-client relationship)
dependence on, 39–40
fear of control/responsibility, 30
as guides, 301
iatrogenesis and, 38–39
internal absorption of, 328
in pain management, 107
passive/permissive view and, 50–51
personal development of, 283
power of, 30, 31, 37, 146–149
scripts and, 43
skills of, 21, 35, 98–99, 115, 391–392, 396
Thompson on, 171
Zeig on, 283
Hypnotizability; *see also* Hypnosis responsiveness; Hypnosis suggestibility
abuse and, 156
attention and, 80, 83, 167, 168
biological marker of, 249–250
brain activity and, 70, 75, 76, 77, 78, 80, 81, 83, 84
communication and, 252–254
of deaf and hearing subjects, 529
definition of, 166, 246
directness of suggestions and, 267
enhancing, 176–178
expectations and, 168–169, 240
formal induction and, 319–320, 321
functions of tests of, 35, 246–247
imagery and, 167–168, 189
informal assessment of, 252
intelligence and, 36–37
mental status and, 174–175
misconceptions on, 31–32
neodissociation model on, 49
Orne on, 227–228
outcomes of treatment and, 250–251
personality and, 36–37, 154, 155–156, 175–176, 239
as responsiveness measure, 32, 36, 80, 166, 228, 239–242, 245
Speigel on, 395
standardized testing cons, 35, 241–242, 245
standardized testing pros, 239–241, 244–245
statistics on, 32, 33, 36, 248, 249
suggestibility compared to, 168, 237
treatment and, 86
Weitzenhoffer on, 479

I

Iatrogenesis; *see also* Hypnosis hazards
defenses of mind and, 100–101
negative manipulation and, 37–38
overview of, 218
scripts and, 321
IBS (irritable bowel syndrome), 124, 136–137
Ideal conditions for hypnosis, 197–198
Ideoaffective responses

applications, 379–380
description of, 60
eliciting, 380, 381
spontaneous, 185
suggestions and, 265
Ideocognitive responses
applications, 378
description of, 60
eliciting, 380, 381
Ideodynamic responses; *see also specific types of responses*
description/application of, 60, 378–380
eliciting, 380, 381
informal induction and, 322, 324, 326
Ideomotor responses
applications, 378–379, 418
description of, 60
eliciting, 380, 381
imagining situations and, 344–345
pendulum and, 252
Ideo-plastic faculty, 129–130, 131, 503
Ideosensory responses; *see also* Sensory alteration
applications, 379
description of, 60
eliciting, 380, 381
Illusion of invisible clinician, 143–144
Imagery
actual experience versus, 189–190
herpes-simplex virus-2 and, 137–138
hypnotizability and, 167, 189
as induction, 118
success imagery strategy, 118, 355, 491
television watching and, 488
Imagination
believed-in imaginings, 54–55, 185, 312–313, 375
children and, 488
exercise in, 157
hypnotizability and, 167–168
ideomotor responses and, 344–345
Immediate early genes, 126, 130
Immobility
catalepsy and, 194, 367–368, 487
negative suggestions and, 335, 336
Immunological disorders, 137
Implied causative link, 295
Implied directives, 275
Impulse control, 458–461
Indirect embedded questions, 357–358
Indirect suggestions
age progression and, 357–358
age regression and, 350–351
amnesia and, 362–363
for catalepsy, 367–368
choice of, 400–401
for closure/disengagement, 385
for dissociation, 372–373
Erickson and, 554–555
in experiential approaches, 522, 524, 525, 526, 527, 528
for eye closure, 264–265, 305
for hallucinations, 377
for ideodynamic responses, 381
metaphors as, 440, 441*t*
overview of, 259*t*, 263–266
for pain management, 506–507, 510–511
resistance and, 267, 555
storytelling and, 404
for time distortion, 383
Individual differences
Erickson on, 99
feedback from clients and, 409
hypnotizability tests and, 246
induction and, 320–321
session transcripts and, 461–462
Sheehan on, 191
Thompson on, 172
Weitzenhoffer on, 479
Induction, *see* Hypnosis induction
Influence
inevitability of, 17
invisible clinician and, 143–144
overview of, 144–145, 157–158, 160–161
Informal hypnotic induction, *see* Hypnosis induction with conversational strategies
Information processes, *see* Cognitive processes; Hypnosis and the mind
Informed consent, 230–232, 290–291, 400
Injunctions, *see* Embedded suggestions
Inner sage induction, 391
Insomnia, 119, 432–433
Institute of Experimental Psychiatry Research Foundation, 226
Instruments for hypnosis responsiveness, *see* Hypnosis responsiveness assessment
Integrative medicine, *see* Hypnosis in behavioral medicine
Integrative model of hypnosis, 178
Intelligence
of animals, 156–157
emotional/social, 477
hypnotizability and, 36–37
Intensifying techniques, *see* Deepening techniques

Internal harmony, 157–161
Internal or external orientation, 328–330, 464
International Society of Clinical Hypnosis (ISH), 540–541
Interpersonal models
  definition of, 48
  experts on, 56
  sociocognitive, 53, 55
Interpretation, 415
Interspersal of suggestions, 275
Intrapersonal models
  altered state of consciousness, 51
  conditioning property of words/experiences, 60
  definition of, 48
  experts on, 56
  neodissociation model as, 49
  reality-testing view, 57
Introductions/forewords (previous), 545–558
  1st Edition, 554–558
  2nd Edition, 550–554
  3rd Edition, 545–550
Introversion/shyness, 25
Intrusions, 198–199, 201
Irritable bowel syndrome (IBS), 124, 136–137
ISH (International Society of Clinical Hypnosis), 540–541

J

Jaw relaxation, 193
Journals on hypnosis, 540, 541

K

Kabat-Zinn, Jon, 524–528
Kidnapping case, Chowchilla, 110, 113
Kinesthetic modality
  analgesia and, 374
  internal/external focus and, 329–330
  preference for, 288–289, 290
  quality of pain and, 501
  relaxed scene and, 309
  sexual dysfunction and, 435
  suggestion examples, 269
Kohen, Dan, 480–481, 492
Kroger, William S., 111–114

L

Labeling experiences, 13–14
Lacrimation, 193
Language; *see also* Communication
  of clients in sessions, 280, 284–285
  patterns of hypnosis, 171
  preferred sensory modality and, 289–290
Large-muscle catalepsy, 366, 367
Learning
  age regression and, 349
  education and, 115–116
  good versus bad people, 214
  psychotherapy and, 209, 211, 517–518
  recency effect and closure, 385
Legal issues
  accuracy of report, 190–191
  false memory and, 110, 230
  formal assessment and, 241
  guidelines on touch, 292
  hypnotic testimony, 114–115, 191, 226, 227, 231, 347–348
  informed consent, 230–232, 290–291, 400
  in medical hypnosis, 108, 501
Lennon, John, 203
Levitation, *see* Arm levitation
Liar syndrome, honest, 114
Lighting, 199
Limitations in life, 94, 175, 213
Lynn, Steven Jay, 545–547

M

Magical thinking, 396–397, 407–408
Magic tricks with children, 489
Manic phase, 175
Manual compounding, 315
Manualized approaches, *see* Scripts
M*A*S*H reference, 455–458
Maternal examples, *see* Mothers
Math example, 173–174
Meanings and words, 99, 171, 285–286; *see also* Transderivational search
Medical hypnosis; *see also* Hypnosis in behavioral medicine
  empowering patients and, 133–135
  labeling and, 14
  medical referral/clearance and, 233, 500
  mind-body relationships and, 121
  overview of, 106–109
  placebo effects and ritual, 124
  procedure avoidance, 136
  secondary gains of pain, 501
  syndromes and hypnotizability, 174
Medications
  antidepressants, 429, 490–491
  effects in sessions, 200
  Haley on, 469

Meditation; *see also* Experiential approaches
brain activity and, 76–77
Eating Meditation, 522–523
hypnosis and, 520
transcript for guided, 524–528
Memory; *see also* False memory
abreactions and, 220–221
age regression and, 226, 227, 346–348, 350
amnesia and, 359–360
confabulation and, 224, 228–229, 347–348, 370
distortion of, 114, 191, 225–227
Eye Movement Desensitization and Reprocessing and, 530
forensics and, 110, 114–115, 191, 230, 347–348
hazards of hypnosis and, 39
misconceptions on, 43–44, 116
posthypnotic suggestions and, 272
resources on, 365
training needed on, 353, 360
trauma and, 224, 226, 549
Memory wars, *see* False memory
Mental absorption, *see* Absorption
Mental health; *see also* Anxiety; Depression
acceptance of hypnosis and, 106
attunement and, 73
brain activity/timing and, 77–78, 85
hallucinations and, 377
hypnotizability and, 174–175
social connections and, 213–214
unconscious and symptom formation, 96, 100
Mental Research Institute (MRI), 100
Metaphors
age progression and, 357–358
age regression and, 351–353
amnesia and, 364
with children, 489
for dissociation, 372–373
with embedded suggestions, 330–334
in experiential approaches, 421, 525
framing, 333–334, 425
for hallucinations, 377
hidden observer, 245
overview of, 275–276, 330, 424–426, 440–442, 441*t*, 442*t*
for pain management, 506–507
symptoms as, 96
for time distortion, 383–384
Middle of nowhere technique, 372
Migraines, 108
Milgram, Stanley, 146–148
Milton H. Erickson Foundation
organization of, 98
overview of, 541–542
Zeig and, 281, 282
Mind and hypnosis, *see* Hypnosis and the mind
Mind-body machine, 485
Mind-body relationships
Barber, T. on, 156
children and, 484–485
epigenetics and, 127–128, 129, 130, 131
healing and, 108–109
medical focus on, 121
miracle cures and, 107, 234
pain management and, 507–508
psychobiological view on, 49–50
research findings, 122
in sports, 117
Mind-clearing/focusing strategies, 433
Mindfulness
brain activity and, 76–77
exercises, 521–522
meditation transcript, 524–528
suggesting awareness and enlightenment, 518–521
Mind's eye closure, 315–316
Minimal cues, 253–254
Miracle cures, 107, 234
Mirroring approach (hands), 129–130
Mirroring of clients, 254
Mirror neurons, 71–74, 141–142
Misconceptions on hypnosis, *see* Hypnosis misconceptions
Modalities, *see* Hypnosis across modalities
Modeling, 368
Modular unit model of brain, 49–50
Monkey research, 72–73
Mood and medicine, 131–133; *see also* Depression; Mental health
Mothers
death example, 417–418
hallucinations on, 376
rejection example, 348
Motivated cognitive commitment, 190–191
Motivation of clients
amnesia and, 360
by Erickson, 291
resources of clients and, 393
self-esteem and, 173
suggestibility tests and, 252
suggestions and, 262
transference and, 190–191
as victims, 288

Movement
catalepsy and, 194, 487
negative suggestions and, 335, 336
MRI (Mental Research Institute), 100
Multiple sclerosis, 134
Muscular relaxation, 192, 306–308
Muscular twitching, 192
Music as communication, 283
Myths about hypnosis, *see* Hypnosis misconceptions

N

Nancy School of Hypnosis, 50
National Pediatric Hypnosis Training Institute (NPHTI), 542
Naturalistic approach, *see* Ericksonian approach
Naturalistic induction, *see* Hypnosis induction with conversational strategies
Needs
for acceptance, 149–151
advertising and, 144
for clarity and certainty, 145–146
for internal harmony, 157–161
Negative hallucinations, 374–375
Negative/minimal response to suggestions, 463–473; *see also* Hypnosis hazards
Haley, Jay, 467–470
negative experience effects, 326
overview of, 463–464, 473
resistance and, 464–467, 470–473, 471*t*
on suggestibility tests, 252
Negative response style, 334–336
Negative self-hypnosis, 174
Negative suggestions
caution with, 286
client information and, 290
overview of, 259–261, 259*t*, 334–336
resistance and, 472
Neodissociation model, 48–49, 69, 184–185, 243–244
Neurofeedback, 77–78, 130, 485
Neurogenesis, 73, 85–86
Neurological health, 133
Neuroplasticity
attunement and, 73
encouraging, 85–86
pain management and, 503
Rossi and, 128–130, 131
Neuroscience of hypnosis, 63–86; *see also* Hypnosis and the brain
New unconscious, 91–94
90-120 basic rest-activity cycle, 128–129
Nocebo effect, 108, 123
Nonconscious, *see* Unconscious functions; Unconsciousness
Nonverbal communication
catalepsy and, 368
Erickson on, 554–555
ideodynamic responses and, 381
voice/demeanor and, 293–294, 317, 322, 517
Nonverbal experiential approaches, 529–532
Nonverbal shifts, 254, 271
Nonvoluntary responding, 302–303; *see also* Automaticity
Norms, social, 27–28, 54
Norms for hypnotizability
cross-national, 248, 249
statistics, 32, 33, 36
No set, 297
NPHTI (National Pediatric Hypnosis Training Institute), 542
Numbness, 504–506

O

Obedience, 146–148; *see also* Compliance
Obesity, *see* Overweight
Olness, Karen, 483–485, 486, 492
Ono, Yoko, 203
Opposites, apposition of, 274
Oppositional mode, 334–336
Optimism
age progression and, 354
health and, 133
as hypnosis hazard, 134–135
quality of life and, 207–208
Organizations, 539–542; *see also* Hypnosis organizations
Orientation
in experiential approaches, 524–525
external or internal, 328–330, 464
to future, 99, 356, 448–451
generalized reality, 56–57
to hypnosis, 401–402
temporal disorientation, 353, 509–510
Orienting subsystem of brain, 69–70
Orne, Martin T., 185–186, 225–228
Other directedness, 142
Outcomes of treatment, 7, 10–12, 250–251
Outside sessions, 199
Overload techniques, 280, 338–339

Overweight
dissociation and, 434
hypnotic phenomena and, 414*t*
suggestions and, 262
transcript of session, 453–455

P

P300 (P3) wave, 67
Pacing statements, 328–329
Pain management, *see* Hypnosis in pain management
Pain threshold, 501–502
Panic attacks, 220, 521–522
Pantomime technique, 529–530
Paradox, 29–30, 276
Parallel processes, *see* Hypnosis across modalities
Parkinson's disease, 133
Parts of people and dissociation, 370
Passive/permissive viewpoint, 50–51, 263
Passivity and brain activity, 83
Pattern building techniques, 415
Pattern interruption techniques, 337–338, 338*t*, 415
Patterns of intervention, 415–426, 419*t*
Patterns of language, 171
PCI-HAP (Phenomenology of Consciousness Inventory-Hypnotic Assessment Procedure), 183
Peanut butter example, 379
Pediatric hypnosis, *see* Hypnosis with children and adolescents
Pendulum test, Chevreul's, 251–252, 251*f*
Perception
of color, 82, 395, 396
conformity experiment, 150–151
flexibility in, 187
hypnosis session on, 212
sensory alteration and (*see* Sensory alteration)
suggestions and, 57–58, 272, 296–297
Permissive/passive viewpoint, 50–51, 263
Permissive suggestions
for amnesia, 362–363
in experiential approaches, 525, 528
for ideodynamic responses, 380
induction and, 304
overview of, 258–259, 259*t*, 271–272
for time distortion, 382–383
Per se exclusion rule, 231
Personal development of hypnotists, 283
Personal history changes, 416–418, 436
Personality
hypnotizability and, 36–37, 154, 155–156, 175–176, 239
responsiveness and, 166–169, 175–176
Personal resources, 89
Pessimism, 133, 207–208, 354
PET (positron emission tomography), 67, 81–82
Phenomenology, *see* Hypnosis phenomenology
Phenomenology of Consciousness Inventory-Hypnotic Assessment Procedure (PCI-HAP), 183
Phobia, airplane, 413–414
Physical characteristics in hypnosis, 192–194, 195*t*
Physical comfort, 200, 221, 305
Physical conditions of clients, 200–201, 221, 305
Physical control, 117
Physical dissociation, 507–508; *see also* Dissociation
Placebo effects
definition of, 107–108, 123
expectations and, 152, 157
hypnosis as, 124, 355
hypnotizability knowledge and, 240
internal consistency and, 158
overview of, 122–125
Places, safe, 310, 491, 526
Play with children, 488
Polygraphs, 378
Positive hallucinations, 374, 375, 376, 416
Positive psychology, *see* Hypnosis and positive psychology
Positive set and hypnotizability, 169
Positive suggestions, 258–259, 259*t*
Positron emission tomography (PET), 67, 81–82
Posthypnotic amnesia
conscious/unconscious and, 90, 95
definition of, 361–362
suggestions and, 272
Posthypnotic suggestions
age progression and, 356
application of learned skills and, 259*t*, 272–273, 393, 404–405
closure/disengagement and, 385
as deepening technique, 317
in experiential approaches, 523, 527–528
failure to remove suggestions and, 229

for pain management, 508
signature strengths and, 213
Stroop effect and, 70–71
victims and, 406
Posttraumatic stress syndrome, 231
Power; *see also* Empowerment
of clients, 39–40, 101–103
clinician-client relationship and, 29–30, 146–149
of clinicians, 30, 31, 37, 146–149
of expectations, 151–152, 157
of hypnotic communication, 257
struggles over, 271, 311
Preinduction talk, 21, 80, 302
Prejudices against hypnosis, 9–10, 112
Presuppositions
age progression and, 357–358
hallucinations and, 377
overview of, 276
for time distortion, 383, 384
Prevention
foresight and, 354
of relapse, 222–223
of sleep in sessions, 200
Primary representation system, 288–289
Priming, 93–94, 144–145
Prison mockup example, 56
Problem ownership and resources, 288
Problem solving, 349
Problem themes, 411–412
Process and content
in goals, 439–440
of mindfulness, 521–523
Process suggestions
age regression and, 349–350
in experiential approaches, 525–526
for hallucinations, 376
induction and, 309–310, 327
overview of, 259*t*, 268–279
for projections, 295–296
resistance and, 471
Process versus content in goals, 439–440
Progression, *see* Age progression
Progressive muscle relaxation, 306–308
Projections, 295–296
Proprioception, 524–525
Pseudo-orientation in time, 356
Psychobiological view, 49–50; *see also* Mind-body relationships
Psychological disorders, *see* Mental health; *specific disorders*
Psychosis, 174–175, 377
Psychosomatic medicine, *see* Hypnosis in behavioral medicine; Mind-body relationships
Psychotherapy; *see also* Clinical practice; Hypnosis in psychotherapy
communication and, 15–17, 551
epigenetic effects of, 126
goals in, 411–412
learning and, 209, 211, 517–518
overview of, 117–119
paradox in, 29–30
Pulse rate, 193
Punishment analogy, 286
Puns, 276, 453–455

Q

Quality of life, 207–208
Quality of pain, 501
Questions
accessing, 273–274
age progression and, 357–358
for children, 482, 486
ideomotor responses to, 378–379, 418
Quiet atmosphere, 198–199

R

Rape, 348–349
Rapid eye movements, 193
Rapid induction signal, 37
Rapport; *see also* Clinician-client relationship
brain activity and, 72, 74
eliciting hypnotic experiences, 325
hypnosis in first session and, 399
integrative model on, 178
metaphorical approaches and, 333, 334, 441–442
mirroring of client and, 254
modeling and, 368
preinduction interview and, 21, 80, 302
special interactional outcomes and, 52
suggestions and, 272
touch and, 292
Reading, 324–325
Reality
hidden observer and, 185, 243–244, 245, 377
perceptual shifts and, 57–58
suggestions and, 226
Reality-testing view, 56–58
Reassociation, affective, 527
Recency effect and closure, 385

Recording
as feedback for hypnotists, 294
for follow-up, 307, 407–408, 511
Referrals
ethical issues and, 232, 233, 500
spontaneous regression and, 222
Referred pain, 496
Refractionation, 317
Reframing
age regression and, 348
client language and, 285
in experiential approaches, 527
in happiness exercises, 212, 214–215
humor and, 276
overview of, 422–424
in psychotherapy, 119
of sex, 436
transcript of session, 451–453
Regressive techniques, *see* Age regression
Reinduction, 317
Reintegration and dissociation, 373
Relapse, 222–223, 356
Relationships; *see also* Clinician-client relationship
confusion techniques for pain and, 509
example of romantic, 270
friendship, 228
mental health and, 213–214
problems with, 430–431, 439–440, 448–451
special interactional outcomes view and, 52–53
Relaxation
anxiety and, 428
brain activity and, 69, 75
catalepsy and, 367–368
comfort and, 200, 305
in dentistry, 110
descending stairs technique, 314–315
dissociation and, 192
epigenetic effects of, 126
of jaw, 193
learning and, 116
misconceptions and, 38, 41–42
negative suggestions on, 335–336
progressive techniques, 306–308
relaxed scene experience, 308–310
voice tone and, 293–294
Relaxed scene experience, 308–310
Renurturing protocols, 417–418
Reorientation, 406–407, 528
Repetition and advertising, 145
Repetitive problem themes, 411–412
Repressed memory, *see* False memory
Research on hypnosis
artistry and, 239, 282, 284, 537, 550
brain studies, 64–68, 84–85, 549
with children, 478
converging forces in, 548–550
demand characteristics in, 226–227
hypnosis as science and, 238
overview of, 7, 10–12
scientific foundation from, 228
standardization in, 176
Zeig on, 282–283, 284
Resistance
eye closure and, 311
indirection and, 267, 555
induction and, 313–314, 322, 327, 330
to overt manipulation, 158
overview of, 464–467, 470, 473
pain management and, 505
passive/permissive view and, 51
responding to, 470–473, 471*t*
suggestibility and, 186
suggestions and, 261, 263, 266, 271–272, 334–336, 465, 466
thinking ahead and, 354
Resource building, 259
Resources and web sites; *see also* Hypnosis organizations
Beck and Yapko, 118
Candid Camera, 145
elephant behavior, 171
Human Genome Project, 125
hypnosis in pain management, 498
interviews with pioneers/innovators, 543
irritable bowel syndrome (IBS), 137
lectures, discussions, demonstrations, 543
Lennon, John and Ono, Yoko, 203
memory, 365
organizations and journals, 539–542
overview of, 426–427
positive psychology, 204
Rossi, Ernest, 128, 129
Resources of clients, 392–393
Response sets
building momentum and, 397–398, 402
in experiential approaches, 523, 525–526
theory on, 168
truisms and, 276, 296–297
Response set theory, 168
Responsibility of clients, 108, 109
Responsiveness, *see* Hypnosis responsiveness
Rest-activity cycle, 128–129
Restaurant recommendation example, 257
Revivification, 345–346, 348–349, 419–420

Right-brain, 76
Risk factors as goals, 398
Risks and anxiety, 427–428
Rituals; *see also* Hypnosis induction with formal strategies
  communication and, 17
  of induction, 41, 303, 319
  placebo effects and, 124
Role-playing model, 54–56
Rossi, Ernest, 49, 127–130, 131
Rumination, 119, 433

S

Safe places, 310, 491, 526
SCEH (Society for Clinical and Experimental Hypnosis), 219, 541
Scene experience, relaxed, 308–310
SCP (sociocognitive perspective), 53–56, 153–154
Scripts
  being hypnotic and, 390
  clinician-client relationship and, 52
  iatrogenic responses and, 321
  misconceptions and, 43
  oversimplification by, 557
  social influence and, 144
  suggestion styles and, 262
  symptomatic treatment and, 223
Secondary gains of pain, 501
Seeding, 364–365, 404, 420–422
Selective attention
  brain activity and, 68
  consciousness and, 94–95
  hypnotizability and, 167, 168
  overview of, 184
  therapeutic approaches and, 516
Self-absorption, 214
Self-definition and care, 443–445
Self-directedness, 141–142
Self-disclosure of clinicians, 148–149
Self-esteem; *see also* Self-image
  compliments and, 287
  homework and, 422
  induction and, 332–333
  problems with, 431–436
  responsiveness and, 173–174
  time distortion and, 384
  transcript of session, 443–445
Self-fulfilling prophecy, 151, 313, 355
Self-hypnosis
  anxiety and, 428
  of Barber, T., 156
  with children, 484–485
  control and, 39–40
  definition of, 6
  education and, 116
  formal experience used in, 326–327
  negative, 174
  for pain management, 511
  sexual performance and, 435
  for sleep enhancement, 432–433
  in sports, 117
Self-image, 37, 151–152, 173–174; *see also* Self-esteem
Self-mastery of children, 494
Self-regulation of children, 491
Self-reliance, 39–40
Seligman, Martin, 204
Senile dementia, 174–175
Sensory alteration; *see also* Ideosensory responses
  application of, 375
  eliciting, 377
  shifts, 57–58, 194, 272
  suggestion examples, 259, 261, 265
Sensory modalities; *see also specific modalities*
  confusion techniques for pain and, 509
  internal/external focus and, 329–330
  overload techniques and, 339
  preferences for, 288–289
  relaxed scene and, 309, 310
Sensory overload techniques, 339
SEPs (somatosensory event-related potentials), 81
Session design and delivery, *see* Hypnosis session design and delivery
Session transcripts, *see* Hypnosis session transcripts
Sexual abuse, 347–349, 549
Sexual dysfunctions, 434–436
Sheehan, Peter, W., 188–192
Shifts
  away from symptoms, 205–207
  in induction approach, 304
  nonverbal, 254, 271
  perceptual, 57–58, 194, 259, 261, 265, 272, 375, 377
SHSS, *see* Stanford Hypnotic Susceptibility Scales
Shyness/introversion, 25
Sight, *see* Visual modality
Signal(s), *see* Cues
Signal value of pain, 496
Signature strengths, 206–207, 210, 212–213
Silence, 293, 316–317

Similarity, 150
Simple conjunction link, 294–295
Sleep
  hypnosis versus, 40–41, 74–75
  insomnia, 119, 432–433
  motion and, 194
  prevention in sessions, 200
Small-muscle catalepsy, 152, 366
Smokers
  age progression and, 356
  depression and, 133
  direct suggestions for, 404
  dissociation and, 414–415, 414*t*
  gender and treatment effects, 172
  scripts and, 43
Snoring example, 423–424
Social brain, 49–50, 73
Social connections, 213–214; *see also* Relationships
Social dependency, 39, 141–142, 149
Social intelligence, 477
Social norms, 27–28, 54
Social psychology of suggestibility, 141–162
  acceptance needs, 149–151
  advertising and influence, 144–145, 157–158, 160–161
  Barber, Theodore X., 153–157
  communication style of clinicians, 161
  expectations, 151–152, 157
  experiential approaches and, 532–533
  illusion of invisible clinician, 143–144
  need for internal harmony, 157–161
  overview of, 141–143, 161
  power of clinician, 146–149
  uncertainty and therapeutic alliance, 145–146
Society for Clinical and Experimental Hypnosis (SCEH), 219, 541
Society of Psychological Hypnosis (APA Division 30), 5–6, 539–540
Sociocognitive perspective (SCP), 53–56, 153–154
Somatic bridging, 353
Somatosensory event-related potentials (SEPs), 81
Sound, *see* Auditory modality
Special interactional outcomes view, 52–53
Special vehicle approaches, 349–350
Spiegel, David, 394–396, 397
Split-brain patients, 76
Spontaneous hypnotic experiences
  amnesia, 361–362
  catalepsy, 367
  ideoaffective responses, 185
  induction and, 301, 323
  regression, 220–222, 346
  Spiegel on, 395
  spontaneous hypnosis, 366
Sports hypnosis, 117
Stage performers of hypnosis
  Barber, T. as, 153, 155, 156
  definition of, 106
  dissociation and, 369–370
  full-body catalepsy and, 366
  hallucinations and, 376
  Kroger on, 112
  misconceptions and, 10, 13, 14, 24–28, 37
  personal relationships and, 53
Stairs (descending) technique, 314–315
Standardization of hypnotic induction, 176, 303–304
Standardized testing of hypnotizability; *see also specific scales*
  arguments against, 35, 241–242, 245
  arguments for, 239–241, 244–245
  in children, 478–479
  clinical/experimental divide on, 237–239
  instruments for, 183, 247–250
Stanford Hypnotic Susceptibility Scales (SHSS)
  clinical practice and, 242, 244
  deaf and hearing subjects, 529
  as gold standard, 69, 248
  Hand Clasp test, 252–253
  Hilgard and, 243
  overview of, 247–248
  Weitzenhoffer and, 33
Stealing example, 423
Storytelling; *see also* Metaphors
  with children, 489
  developing skill at, 334
  indirect suggestions and, 404
  overview of, 424–426
  rapport and, 441–442
Strategic therapy, 313, 551; *see also* Hypnosis session design and delivery
Strength(s)
  focus on, 175
  positive psychology and, 205, 206
  signature, 206–207, 210, 212–213
Strength-based framework, *see* Hypnosis and positive psychology
Stress
  of childhood, 476–477, 484
  communication and, 404–405
  crime and, 115
  depression and, 132

healing and, 136
immune functioning and, 137
induction and, 332–333
medical hypnosis and, 107
overview of, 427–428
pain management and, 396
posttraumatic, 231
transcript of session, 455–458
Stress management, 455–458
Strokes, ischemic, 133
Stroop effect, 70–71
Stuck, being, 40, 530
Subjective experience of hypnosis, *see* Hypnosis phenomenology
Subjects, *see* Clients
Substance abuse, 432, 433–434; *see also* Overweight; Smokers
Success imagery strategy, 118, 355, 491
Suggestibility, *see* Hypnosis suggestibility
Suggestions; *see also* Hypnosis suggestions
in experiential approaches, 518–519, 523, 524–528
Eye Movement Desensitization and Reprocessing and, 531–532
therapeutic approaches and, 516, 517
Susceptibility, *see* Hypnotizability
Sustained attention, 80
Symptomatic hypnosis, 174
Symptoms
clinician understanding of, 467
homework on, 422
hypnotic phenomena and, 174, 412–414, 414*t*
repetitive problem themes, 411–412
shift in focus from, 205–207
substitution of, 222–223, 508–509
trauma and, 347
unconscious and, 96, 100
Symptom substitution, 222–223, 508–509
Systemically informed intervention, 431

T

Targets, *see* Goal(s)
TAS (Tellegren Absorption Scale), 168
Task assignments, 99
Tears, 193
Technology
in brain research, 66–68, 84–85, 549
children and, 476
television watching, 145, 333, 488
virtual reality (VR), 512–513
Teeth grinding, 110
Television watching, 145, 333, 488
Tellegren Absorption Scale (TAS), 168
Temporal disorientation, 353, 509–510; *see also* Time distortion
Temporal quality of pain, 501
Testimony, *see* Hypnotic testimony
Testing hypnosis responsiveness, *see* Hypnosis responsiveness assessment
Theoretical perspectives, *see* Hypnosis theories
Therapeutic alliance; *see also* Clinician-client relationship
environment and, 198
expectations addressed in, 152
hypnosis in first session and, 399
integrative model on, 178
preinduction talk and, 21, 80, 302
uncertainty and, 145–146
Therapy, *see* Clinical practice; Psychotherapy
Thermal quality of pain, 501
Theta state, 75, 78
Thinking, magical, 396–397, 407–408
Thompson, Kay F., 170–172
Three good things in life, 210, 212
Three Little Pigs, The, 263–264
Thyroidectomy, 497–498, 504–505
TIAs (transient ischemic attacks), 133
Time
for closure/disengagement, 291, 385, 406
distortion in (*see* Time distortion)
pain and, 501
pseudo-orientation in, 356
Time distortion
description/application of, 381–382
eliciting, 382–384
in experiential approaches, 526, 527
for pain management, 511
suggestion examples, 261, 262, 265
temporal disorientation, 353, 509–510
Touch
anchor and, 417
manual compounding and, 315
quality of pain and, 501
selective and permitted, 292
Traditional approaches, *see* Hypnosis induction with formal strategies
Train approach, 349–350
Training in hypnosis
hazards of hypnosis and, 218–219
on memory mechanisms, 353, 360
need for, 535, 558

next steps in, 536
personal development, 283
on storytelling, 334, 426
Thompson on, 172
for trauma, 221, 222
Trance
Barber, T. on, 153
Hilgard on, 245
Kirsch on, 169
Kroger on, 112
Lynn on, 547
responsiveness and, 272
Weitzenhoffer on, 34
Yapko on, 548, 550, 553
Trance logic, 57, 185–186, 364
Transcript of guided mindful meditation, 524–528
Transcripts of sessions, *see* Hypnosis session transcripts
Transderivational search, 59–60, 252, 404–405
Transference and motivation, 190–191
Transient ischemic attacks (TIA), 133
Transitional statements, 304
Trauma; *see also* Abuse
amnesia and, 359–360
clinician training for, 221, 222
critical incident process and, 418–420, 419*t*
dissociation and, 368, 369
Eye Movement Desensitization and Reprocessing and, 530–531
memory and, 224, 226, 549
mindfulness exercises and, 521–522
stress and, 115, 231
symptoms and, 347
Treatment compliance, 122; *see also* Compliance
Treatment dynamics, 439–442, 441*t*, 442*t*; *see also specific dynamics*
Treatment plans, 272, 390, 408–409; *see also* Hypnosis session design and delivery
Truisms and response set, 276, 296–297
Trust, 417
Truth and recall, 43–44, 224, 227, 347–348
Try and do challenge modes, 252
Twin studies, 125–126
Twitching, muscular, 192

U

Ultradian rhythms, 128–129
Uncertainty, 145–146, 159, 337
Unconditional positive regard, 72
Unconscious functions
age progression and, 354–355
amnesia and, 90, 95, 360–361, 363–364
automaticity and, 91–94
brain activity and, 76
confusion techniques and, 337, 338–339
criminal investigations and, 110
dissociation and, 369, 371
Erickson on, 331–332, 361
in experiential approaches, 524–525
ideodynamic responses and, 381
myth on power/benevolence of, 101–103
new, 91–94
overview of, 95–96, 97–98
potential and, 553
psychotherapy and, 118
resistance and, 464
Rossi on, 130
session transcripts on (*see* Hypnosis session transcripts)
suggestions and, 89, 95, 260, 263–264, 266, 269–270
symptom formation and, 96, 100
Unconsciousness versus hypnosis, 40–41, 74–75
Unfinished business, 221
Unsuccessful hypnosis, *see* Negative/minimal response to suggestions
Utilization approach, *see* Ericksonian approach
Utilizing and accepting, *see* Accept and utilize formula

V

Vehicle approaches to regression, 349–350
Verbal compounding, 199, 201, 294–295, 315
Vicki, case of, 3–4, 511–512
Victims
avoidant coping style and, 434
misconceptions and, 36
motivation and, 288
posthypnotic suggestions and, 406
therapeutic themes and, 403
Video-recording as hypnotist feedback, 294
Virtual reality (VR) technology, 512–513
Virtuosos, hypnosis, 31, 248
Visualization, 413–414
Visual modality
internal/external focus and, 329–330
preference for, 288–289, 290

quality of pain and, 501
relaxed scene and, 309
Vitamin supplement experiment, 159
Voice tone, 293–294, 317, 322
VR (virtual reality) technology, 512–513

W

Waking hypnosis, 41–42, 421
Waking state, *see* Awake state
Watkins, John (Jack), 5
Weak-minded, *see* Will
Weaknesses, 205–207
Web sites, *see* Resources and web sites
Weight loss
dissociation and, 434
hypnotic phenomena and, 414*t*
suggestions and, 262
transcript of session, 453–455
Weitzenhoffer, André M.
on 2nd Edition, 550–552
Hilgard and, 33, 34, 69, 243, 247
on hypnotizability, 479
overview of, 33–35
Whining story, 204–205
Will
misconceptions and, 22, 26, 29, 36–38, 520–521
unconscious and, 92
Witness testimony, *see* Hypnotic testimony
Words and meanings, 99, 171, 285–286; *see also* Transderivational search

Y

Yes set, 296–297; *see also* Response sets

Z

Zeig, Jeffrey K., 281–284, 554–555